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THE MEDICAL JOURNAL OF AUSTRALIA

VOL. II.—30TH YEAR. SYDNEY, SATURDAY, JULY 17, 1943. No. 3.

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The Parliamentary Joint Committee on Social Security: Sixth Interim Report on a Comprehensive Health Scheme.

PART I. THE PROBLEM.

Terms of Reference.

1. Associated with the terms of reference of the Joint Committee on Social Security as resolved by Parliament on the 3rd July, 1941, viz., "To enquire into and from time to time, report upon ways and means of improving social and living conditions in Australia and of rectifying any anomalies in existing legislation", are health services for the Australian people.

2. Included among the specific proposals referred to the Committee by the Government, through the Minister for Social Services and Health on the 21st July, 1941, was "A Comprehensive Health Scheme" including: (*a*) Child Welfare. (*b*) Maternal Welfare. (*c*) Nutrition. (*d*) Community Medical Service including Hospitalization.

3. On the 17th October, 1942, a letter was received from the Federal Treasurer requesting the Committee's advice concerning health services, with particular reference to such measures as it might be possible to introduce during the period of the war.

4. Compliance with this request necessarily involved consideration of health services as a whole, so that any measures recommended for introduction during the war should be integrated with a complete plan of health services for Australia, for introduction at a later stage.

Wartime Measures and Planning.

5. In its advance recommendations to the Government by letter dated the 13th January, 1943 (Appendix "A"), the Committee dealt particularly with wartime measures including:

(1) Services to be planned—some of which may be partially introduced—during the war, and

(2) Measures recommended for early introduction including:

(*a*) Financial measures to provide economic assistance to (i) persons suffering from temporary incapacity; (ii) expectant and nursing mothers; and (iii) tuberculosis sufferers and their dependants;

(*b*) a grant of £50,000 to provide treatment for venereal disease and for educational purposes in this regard; and

(*c*) a grant of £100,000 for child welfare.

6. In this letter, the Committee drew attention to the shortcomings of the *National Health and Pensions Insurance Act* 1938, and recommended that no action be taken to implement any of the provisions of that legislation in its present form; the Committee also gave it as its considered opinion that it is not possible successfully to introduce a comprehensive health scheme during the war, but stated that it proposed to proceed with the planning of such a scheme.

Health Service Requirements.

7. The task confronting the Committee was to determine the nature and extent of Health Services necessary and adequate for the Australian people, and to make such proposals as would provide these services.

8. The conception of health services adequate for this purpose is one which provides the highest degree of physical and mental health attainable, through (*a*) healthy social and living conditions, and the maintenance of economic standards sufficient to provide adequate nutrition for all in the community, and facilities for (*b*) the pursuit of positive health, the prevention and early detection of disease or physical defect, and (*c*) the treatment and care of disorders and diseases.

9. As it concerns the control of Health Services generally in Australia, it is worthy of note that the decisions of the convention at Canberra in November, 1942, in enumerating desirable extensions of Commonwealth legislative power, included the clause "National Health Services in co-operation with the States". While there is uncertainty as to the legal interpretation of this clause, and particularly of the words "in co-operation with", the fact that the convention's decisions have not been ratified leaves the present constitutional position unaffected unless some measure of further agreement between the Commonwealth and the States is reached. The alternative to a constitutional change is a financial grant by the Commonwealth to such States as agree to give effect to the proposed scheme for health services. Whatever may be the solution of the legal problem it is necessary to point out also that the successful introduction of any comprehensive scheme for health services could be accomplished only after discussions between all interested parties had resulted in mutual agreement on details. This implies inevitably complete co-operation between the Commonwealth and the States, the medical profession and the general public.

Existing Facilities.

10. Medical care in Australia is provided under two main headings, as follows:

(1) "Positive Health", i.e. preventive medicine—which includes public health and research, and is financed very largely by Governments. Private medical men are not sufficiently associated with it at present.

(2) "Curative Medicine"—which includes (*a*) general medical work, largely the province of private medical practitioners; and (*b*) hospital care, partly the province of private hospitals, but increasingly controlled by public hospitals under Government or part-government direction.

Positive Health.

11. The Commonwealth and all State Governments undertake various aspects of "positive health" work or preventive medicine.

12. Protection against any invasion of the Commonwealth by infectious disease from abroad is afforded by the quarantine service which is staffed by the Commonwealth Department of Health.

13. The control of infectious diseases, the standards of food and drugs, the cleanliness of premises and the adequacy of water supplies and disposal services, are all the responsibility of State Health Departments, with decentralized control in the hands of local authorities. Research is undertaken by the Commonwealth and all State Departments, by a few hospital organizations and by still fewer specially endowed scientific institutions.

14. The general co-ordination of these aspects of medical care is attempted through the National Health and Medical Research Council of the Commonwealth, set up in 1937. This body, which meets twice yearly, includes representatives (three) of the Commonwealth Department of Health; the Directors of Health of each State Department of Health; one representative each of the British Medical Association, the Royal Colleges of Surgeons and of Physicians of Australasia; and of the (combined) Australian Universities having medical schools, and also two lay representatives. The Council discusses all important aspects of public health from time to time; compiles reports, and makes recommendations as to the best means of attaining uniformity in health policy, or undertaking any action that these discussions demonstrate to be appropriate. It also examines applications for assistance with scientific research proposals of a medical nature, and determines the distribution of Commonwealth funds available for research purposes. It has made important recommendations, among others, concerning public health, maternal and child welfare, national fitness, health protection by immunization and other prophylactic measures, the investigation and treatment of cancer, etc., and has set up a number of semi-permanent sub-committees to deal with particular aspects of the problem of medical care in Australia.

15. The powers of the Commonwealth are limited by the Constitution to "quarantine", but these have been expanded by agreement to include many other fields of activity. One of the most valuable of these is the establishment of laboratories at strategic points throughout the Commonwealth, e.g. at Cairns, Townsville, Rockhampton, Toowoomba, Lismore, Bendigo, Hobart, Launceston, Port Pirie, Kalgoorlie, Broome and Darwin. These not only assist medical practitioners with facilities for diagnosis and by the provision of protective serum, but they make special attempts to investigate local problems, e.g., silicosis at Kalgoorlie, W.A.; tropical diseases at Cairns and Townsville, Queensland, and so on. The serums distributed are provided by the Commonwealth Serum Laboratories at Parkville, Victoria, which have grown to be an organization of the very greatest importance, now supplying not only the needs of Australia and New Zealand but also, during the war, making valuable contributions to the needs of Africa and Southern Asia.

16. The School of Public Health and Tropical Medicine associated with the University of Sydney was erected by and is staffed from the Commonwealth Department of Health.

17. The Commonwealth has also initiated and financed pre-school child welfare clinics in each of the capital cities, and has co-ordinated and assisted the organizations for national fitness, which are operating successfully in all States.

18. War necessity has greatly advanced throughout Australia, the matter of industrial hygiene, especially from the point of view of workers in hazardous industries, and has brought some aspects of it into the Commonwealth field.

19. Originally, the responsibilities that were financed by governments were, until 1900, restricted almost entirely to the care of sanitation and control of infectious diseases. For this purpose the State governments have the ultimate assistance of all local authorities in the local government areas into which the whole populated portion of the Commonwealth has, for many years, been subdivided.

20. The public has become so accustomed to the routine maintenance of sound sanitary conditions in premises in all the cities and towns that mass interest has, during the last 40 years, been deflected to personal hygiene—the protection of the health of the individual from the cradle (and before it) to old age by the departments of public health; and mass attacks on problems such as tuberculosis, venereal disease, cancer, etc. Governments, moreover, in pursuing these objectives, have found it necessary more and more to enter the field of public curative medicine, and to provide the essentials of general medical care to larger and larger sections of the public. This had led to a realization of the need for organization of these multiple activities, and the study of means for that purpose has demonstrated a conspicuous lack of uniformity in the health services, both preventive and curative, existing in Australia.

21. The deficiencies in the public health provision may be summarized as being

(*a*) the restricted powers of the Commonwealth in respect of health;

(*b*) a lack of uniformity in the legislation for health and the organization of health (including hospital) services in the six self-governing States;

(*c*) a needless separation of the health problem into unrelated parts under separate controls by failure to recognize their unity in essence;

(*d*) a lack of adequate training of medical students in public health as part of their medical course, with a consequent ignorance of and indifference to the subject among medical practitioners;

(*e*) the tendency for medical men to seek their living where they can best find it, which is neither in public health work nor in research; and

(*f*) the fact that far too few full-time medical positions exist in State or Commonwealth health services and those that do are often unattractive because of the excess amount of office routine and because of lay control or interference in respect of specialized programmes;

(*g*) the lack of standardization with regard to infectious diseases hospitals and technique; and the need for the establishment of infectious diseases hospitals on a basis plan throughout the Commonwealth in accordance with population distribution and infection risk.

Medical Care.

22. Though the standard of medical practice in Australia is undoubtedly high, the conditions of private practice under which by far the greater part of it is carried on, exert undue strain on the doctor while at the same time they render the service unequally available to all sections of the population. To that section—the middle income group—of the population which is ineligible to receive the free treatment provided to the poor by combined charitable and government agencies, and by individual doctors, and which at the same time is not financially able, as are the rich, to meet the large unexpected increases of expenditure which illness may bring about—real hardship is often caused. Only a relatively small proportion of this section is relieved from this position to any extent by the various benefit and insurance funds set up by Friendly Societies and other such organizations.

23. In general, curative services, except for the indigent, have until recently been provided by private medical practitioners and practising specialists in private and public hospitals. For efficiency and economy, the organization of public hospital services has gone on increasingly, and the number of full-time salaried medical men, now working in public hospitals, is great and is increasing. There is beginning to be, therefore, an appreciable proportion of medical men occupied either as full-time government medical officers, medical superintendents and medical officers in hospitals, and research workers, although this tendency is more marked in some States than in others.

24. In Tasmania it has recently become the policy of the government to provide salaried medical officers to carry out both preventive and curative medical work over a large part of the whole State; in Queensland the policy of providing full-time officers and, occasionally, complete full-time staffs to the base

hospitals dominating various health districts, has been increasingly evident.

25. In certain remote areas of Western Australia, salaried medical officers are appointed for a limited term as members of the Flying Doctor Service and provide both preventive and curative care.

26. In the Northern Territory of the Commonwealth a full-time government salaried service exists to the exclusion of all private medical practice.

27. In Queensland, alone among the States, an endeavour has recently been made to define the conditions under which medical men may set themselves up as specialists, by the institution of a "Register of Specialists" governed by statute; moreover, the specialist services provided to the large Brisbane Hospital, which were formerly, as in all other States, provided on an honorary basis, have now been made part-time salaried posts.

28. Nevertheless, the great mass of medical care is undertaken by medical men under private practice conditions and an unfortunate result of such conditions is seen in the distribution of doctors in relation to population. The more attractive residential suburbs, where need for medical care might be expected to be less, are generously supplied with doctors. Unattractive industrial suburbs, where economic factors operate most strongly to produce accidents and diseases, are under supplied. Country districts, particularly those remote from a large town, are badly supplied with medical aid.

29. An obligation rests on any government desiring to safeguard adequately the health of its people and the welfare of all sections, which can be expressed in simple terms thus:

(*a*) To render good medical aid equally available to all classes and so far as possible all individuals in the community; and

(*b*) to work for the improvement of the standard of the medical profession generally by (i) increasing facilities for research; (ii) by making possible to every medical practitioner frequent refresher courses of post-graduate study; and (iii) lessening the strain on individual members of the profession.

Hospital Care.

30. Hospital services are provided under a system of government, public and private hospitals of very great variety and of different standards of efficiency.

31. The government and public hospitals generally provide accommodation and treatment for public patients unable to make any, or more than a partial contribution towards the cost of their maintenance. This necessitates the major cost of the service being provided at government expense, or from funds raised by public subscription or organized appeals.

32. Some public hospitals, however, have in recent years developed "intermediate" and "private" sections where accommodation is provided for patients able to pay in full.

33. In the Northern Territory medical and hospital services are financed by a tax for this purpose imposed on all residents, and these services, therefore, are provided free by a salaried medical service and by government hospitals.

34. Private hospitals are conducted as business undertakings or as a form of denominational service and, in all cases, patients are required to pay the full cost of the service provided.

35. Some of the larger of these institutions are well equipped and do substantially relieve the demand on public hospitals. For economy reasons the smaller type of private hospital, however, is not organized or equipped to give adequate service to patients in accordance with modern standards.

36. Special hospital services are provided for tuberculosis and mental diseases, but these are, in the main, controlled and financed by the Government.

37. It is here necessary to make some general observations to indicate the nature and extent of the hospital problem—

38. *The quantity of hospital accommodation:* Assuming the present population of Australia to be 7,150,024, the standard requirement of beds in general hospitals is 64,350, in hospitals for tuberculosis 5,492, and in mental hospitals 32,169. The beds available in the 1,809 hospitals in Australia are general hospitals 57,660, tuberculosis hospitals 2,439, and hospitals for mental diseases 25,175.

39. Deficiencies of beds are, therefore, general beds 6,774 (allowance is made for 84 beds for venereal diseases for which there is no accepted standard), tuberculosis beds 2,963, and beds for mental diseases 6,994; total 16,731 beds. This approach considers the problem on a broad basis for the whole of Australia. It must, however, be viewed in relation to each metropolitan area and each country district of each State. It is evident that there is a serious deficiency of hospital accommodation in Australia, which, on dissection, is most acute in the capital cities of the mainland.

40. There is evident also a failure to classify hospital beds. The chief deficiencies exist in the provision of sufficient accommodation for sub-acute and chronic diseases and for convalescent patients.

41. It would seem that very little relief can be expected from the use of military hospitals after the war.

42. *The quality of hospital accommodation:* The quality of hospital accommodation for both patients and staff in the hospitals of Australia leaves much to be desired. The number of hospitals which can be regarded as measuring up to world standard of quality is extremely small.

43. Location is in many cases bad; there are defects of construction and planning for expansion; equipment generally is of low standard, especially in facilities for the primary need of surgical asepsis; there are menaces due to uncleanliness and to unnecessary exposure to infection and many hospitals lack adequate staff.

44. Proper diagnostic facilities (X-ray and laboratory) are very deficient in country areas.

45. It will be seen, therefore, that there is need for considerable increase in the quantity of hospital accommodation and for a vast improvement in the quality of hospital equipment and service, especially in the direction of additional diagnostic services in the country.

46. *Outpatients' services:* Persons seeking outpatient treatment in our capital cities must attend centralized outpatient departments and here congestion and a long waiting period is the rule. This frequently involves the patient in many visits, each possibly covering wearisome travelling and expense, which imposes hardship and unduly long absence from work or neglect of household duties.

47. *Maternal and Infant Welfare:* Apart from a few modern maternity hospitals throughout Australia, facilities for maternal and infant welfare are conspicuously lacking in proper standards of accommodation and equipment and many such hospitals should not be permitted any longer to function.

48. *Tuberculosis:* Facilities for the accommodation and treatment in hospitals and sanatoria of tuberculous patients are tragically short of urgent requirements. Arrangements for the early detection of tuberculosis by systematic examination and for the occupational rehabilitation of those who are past the infective stage are hopelessly inadequate. There is also no proper provision for the financial relief of the dependants of patients who, in the interests of the community, must be placed in hospital and sanatoria.

49. *Mental Diseases:* The bed accommodation available for patients suffering from mental diseases falls short by 6,994 beds of standard requirements. The provision of this type of accommodation is remarkably constant in all States (mean provision for Australia 3·4 beds per 1,000 population), but gross overcrowding is apparent everywhere. Generally the treatment of mental diseases throughout Australia is in a most unsatisfactory state and urgently requires modernizing and improving.

Nursing Services.

50. There are anomalies in conditions of training, rates of pay and conditions of employment in the various States. The standard of accommodation in hospitals for nursing staff is deficient in quantity and, on the average, poor in quality in a great number of hospitals. There is a gap between the school leaving age and the age at which a girl enters on nursing training. There is evidence of a decreasing number of girls entering the nursing profession and the quality of the type offering is not up to the standard previously applied.

Ancillary Services.

51. These include Laboratory, X-ray, Physio-therapy, Almoner, Dietitian, etc. There is a great deficiency in the provision of a good standard of service in these aids to diagnosis and treatment which is particularly marked in country districts. Even in some districts where buildings and equipment are provided, they are not functioning because of lack of trained staff.

National Health Insurance.

52. National Health Insurance has never been part of the Health and Medical Services of this country. In Great Britain and in some other countries, it has become, during the last 30 years, one of the major factors in the medical care of the public, though its incompleteness has been freely admitted.

53. At the time of its introduction, it was hoped that the *National Health and Pensions Insurance* 1938, might represent an advance upon the health services then available to the general public throughout Australia. It was certainly an acknowledgement that in some respects there were deficiencies in such services and that there was a need for more comprehensive services of a uniform nature. This need has never been met.

54. The Committee is impressed by the existing widespread opposition to the proclamation of this Act, and concludes from it that the scheme there suggested is unsuitable as a permanent basis for social benefits or health services for the people of Australia. In particular, the Committee has observed (*a*) the absence of medical benefits for the dependants of an insured person; (*b*) the absence of provisions for hospital service, or maternal and child welfare; (*c*) the limitation of benefits to a specified income group; (*d*) the association of medical benefits and cash benefits under one administration; (*e*) the absence of any provision for assistance during periods of unemployment (one of the chief causes of malnutrition and ill health); and (*f*) the disadvantages inherent in the method of payment for medical services proposed, viz. capitation fee and panel system.

55. In our opinion, this Act lacks provisions that are essential to any comprehensive health service adequate for the needs of the community as a whole, and fails to provide an acceptable basis upon which any such service may be satisfactorily planned. We, therefore, favour the repeal of this Act.

Alternative Proposals.

56. There are many divergent views within the medical profession in Australia as to the health service best suited to Australian conditions. Both the National Health and Medical Research Council, however, and the Federal Council of the British Medical Association in Australia agree that its essential principles must be

(*a*) to provide a system of medical services directed towards the achievement of positive health and the prevention of disease and the relief of sickness; and

(*b*) to render available to every individual all necessary medical services, both general and specialist and both domiciliary and institutional.

57. Throughout its inquiry into health services the Committee has sought the opinions of representative members of all sections of the people over the widest possible field, including State Governments, Commonwealth and State health authorities, the medical profession and related activities and the general public, including social, political and industrial organizations.

58. At the outset, the chief proposals for investigation before the Committee were two, viz.:

(1) The recommendations of the National Health and Medical Research Council, as contained in the reports of the 11th and 12th sessions (July-November, 1941). These set out a tentative outline for a comprehensive health service for Australia, including both the preventive and curative aspects of medical care under Commonwealth control and by means of a full-time salaried medical service.

(2) A General Medical Service for Australia, as outlined by the Federal Council of the British Medical Association in Australia in its memorandum dated September, 1941.

59. In addition, the Committee had available to it details of the plan provided by the New Zealand *Social Security Act* 1930, for health and other benefits and, in particular, Medical benefits (provided under two alternative systems of payment to doctors, viz. a capitation fee system and a fee-for-service system). Maternity benefits, hospital benefits, pharmaceutical benefits, and ancillary services benefits including massage, dental and diagnostic aid services. The Committee also had the advantage of discussions in Australia with the Chairman, Social Security Commission, and the Secretary, Department of Health, New Zealand.

60. Although the proposals for health and rehabilitation services contained in Sir William Beveridge's report to the British Government (Assumption "B") leave much detail to be developed, access to this document has also been of considerable assistance to the Committee.

61. All the proposals mentioned may be accepted as acknowledgements of the need for improved and more complete Health Services more fully available to all sections of the people under existing conditions.

Health Council Plan.

62. The proposals of the National Health and Medical Research Council were prepared as a basis of discussion. At the request of this Committee, these were later supported by estimates of the costs of the various services suggested and other financial details.

63. The Council prefaced its recommendations by a statement of certain general principles. The first and most important of these was that health is no simple matter but is determined by a complex of social conditions; the next that the obligations of the community in the maintenance of community health cannot be discharged if the community does not provide sufficient funds to enable the public health departments to do those things which in their opinion should be done; that it was of the utmost importance that a higher state of personal health should be established and maintained throughout the whole community, and that all the necessary powers and resources of both Commonwealth and State should be applied to ensure this result; that the rapid development of medical practice along lines of specialized work had produced a complex of uncoordinated activities all concerned with the care of individual health but becoming more and more divorced from the principles of prevention of disease, because of a lack of any proper administrative organization for bringing together all aspects of medical care.

64. The Council accordingly recommended that:

(*a*) The whole populated area of the Commonwealth should be divided into Health Districts which should also be hospital districts as far as possible;

(*b*) a District Health Officer should be appointed to each Health District (or to two or more combined). Each District Health Officer should be an Officer of the Central Health Department of the State and should be directly appointed by Commonwealth or State. His activities should cover a wide range and, among other things, the supervision of all health legislation and preventive medicine in his district and co-operative association with hospital services;

(*c*) the hospital services throughout the populated area of the Commonwealth should be arranged on a district hospital system with base and subsidiary hospital centres. Local centres should be staffed by local medical men, the central hospitals kept for specialist cases. (Elaborate provisions were laid down for staffing the whole system by salaried medical men, with the proviso that the Council considered that these proposals were not inconsistent with the retention of private medical practice and private hospitals.)

65. The far-reaching nature of the proposals—particularly those relating to a full-time salaried medical service and the establishment of health centres in strategic localities, including country towns, as bases for such a service—provoked keen discussion and differences of opinion among members of the medical profession.

66. The scheme (other than certain schedules) was published in detail in *The Medical Journal of Australia* of December 20th, 1941, and was thus made available to the great majority of medical practitioners in Australia. In 1943, following a revival of interest in proposals for a salaried service, special meetings of State Branches and of the Federal Council of the British Medical Association in Australia were called to discuss the future of medical practice and, especially, any proposals for a salaried medical service.

67. The Committee, after considering the published reports of certain of these meetings, and the evidence given before it by witnesses, is of the opinion:

(1) That a substantial majority of medical practitioners object to a general salaried medical service on lines laid down by the National Health and Medical Research Council or any other lines put forward up to date.

(2) That, on the other hand, there is general agreement that a salaried medical service may be justified in remote areas;

(3) That there is practical unanimity of opposition from all private medical witnesses to any proposal for control of any general health service by any government department; and support for control by an independent body or commission, including a majority of medical men, if such a general health service should be introduced.

(4) That there are indications that a more favourable attitude towards a salaried medical service may exist among medical officers of the fighting services; but it is not possible accurately to assess the situation without consulting every member individually.

68. There is general agreement among witnesses that hospital services should be greatly improved and placed under a uniform system of control, and also that uniform standards should be established and strictly maintained. There is general support of the proposal for the establishment of health clinics in suburbs to decentralize out-patient services and, generally, as an encouragement to the development of group medical practice.

British Medical Association Plan.

69. Recently the Federal Council of the British Medical Association reviewed its 1941 plan and in its place submitted to the Committee on 20th May, 1943, a new set of proposals containing a statement of "general principles" governing health services.

These were primarily four in number, as follows:

(i) That the system of medical service should be directed to the achievement of positive health and the prevention of disease no less than to the relief of sickness.

(ii) That there should be provided for every individual the services of a general practitioner or a family doctor of his own choice.

(iii) That consultants and specialists, laboratory services, and all necessary auxiliary services together with institutional provision when required, should be available for the individual patient, normally through the agency of the family doctor.

(iv) That the several parts of the complete medical service should be closely co-ordinated and developed by the application of a planned national health policy.

70. Apart from this general declaration, the chief features of this document are:

(*a*) Opposition to any drastic change in medical services during the war and for one year thereafter.

(*b*) Opposition to a Nationalized Salaried Medical Service with consequent abolition of private practice.

(*c*) Offer of willing co-operation in effecting certain improvements considered essential by the British Medical Association in existing medical services.

(*d*) As a development of (iii) above:

Optimum efficiency of medical service by utilizing the existing consultant, general practitioner and hospital services but with additions including nutrition and housing standards; research; decentralized diagnostic centres; extended consultant services; group practice; extended flying doctor services; subsidization of practitioners in outback centres; extended industrial, venereal, immunological and other preventive medical services, and maternity services.

Extended hospital and equipment facilities for tuberculosis and mental diseases, the crippled, bedridden and aged, "private" and "intermediate" wards in hospitals, and

Subsidized extended post-graduate training.

(*e*) Control by a corporate body including lay members and medical men—the latter to constitute a majority and to be nominated by the practising medical profession; and

(*f*) Disciplinary control by the medical profession only, of members accepting service.

71. The experience of National Health Insurance and the prolonged but inconclusive negotiations to arrive at a basis of payment for medical service under the 1938 Act have unquestionably influenced the attitude of the medical profession generally to any national health service. Notwithstanding this, good relations have been established between the Committee and the Federal and State Councils of the British Medical Association, and with medical practitioners generally, including non-members of the Association. We record our appreciation of the co-operation of all witnesses and the frank way in which they have expressed their views. The Committee believes that it has thus been enabled to correctly assess the merit and acceptability of the various views and proposals submitted to it.

PART II. SUGGESTED SOLUTION.

Preventive Health.

72. At this point the Committee thinks it imperatively necessary to declare, with the utmost possible emphasis, that no policy of preventive or curative solicitude for public health can succeed in a community which does not give economic security to all its people. Adopting an ancient maxim, the Committee affirms that a nation must guarantee to each of its members an assured livelihood before it can promise him that irreducible minimum of health without which he can be neither a fully useful citizen nor a normally happy human being. Having sounded this warning note, the Committee returns to the task that Parliament has set it, of reporting upon one phase only of national life, considered for the moment, as if it could be isolated from all other phases.

73. Up to the beginning of the present century, it was commonly believed that "public health" consisted only of measures for the sanitation of premises, the inspection of foods and drugs, the distribution of pure water supplies, the regulation of buildings, the provision of sewerage, the adequate disposal of nuisances and refuse, regulations for marketing and the lighting of towns, provisions for the burial of the dead without injury to the living, and the control of infectious diseases and of causes that might set them up.

74. The utilization of government funds for these purposes was regarded as normal, but there was some tendency to consider that, except for the provision of hospitals for the destitute, any other expenditures were unjustified.

75. In the more recent years it has come increasingly to be recognized that a considerable number of measures affected the health of the public and that, in fact, expenditures upon any one of these, or all of them, are not only justified but are economic measures of great value which save considerable costs later on. It is also becoming recognized that it is extravagant to go to great lengths to cure people of the immediate effects of disease and then to allow them to return to circumstances likely to break down the good work done or to re-establish the disease itself.

76. It follows from this conclusion that the problem of health must be regarded as a single problem and that the preventive aspect must permeate every section of it. This indeed is the teaching in the most advanced medical school. Moreover, it is recognized that the government may legitimately spend money upon any aspect in which private enterprise is unable to handle situations detrimental to the welfare of the people, or to initiate action in any neglected field.

77. Recognizing the unity of the problem, its main section may be set out under appropriate headings such as:

Protective activities;
Specialized activities for safeguarding maternity;
Corrective activities;
Adaptative activities, sociological as well as medical;
Economic accessory activities; and
Educative activities.

78. Since these activities form a complete picture of health work, and since there is a definite public health aspect in every one of them, as will be obvious, they may be set out in detail as follows:

Protective activities, including:

(*a*) The sanitation of environment; the health standards of housing;
(*b*) the care of the quality, quantity, and balance of foods;
(*c*) the specialized protection of certain age-groups and states, e.g. mothers, infants and pre-school children, school children, young workers in industry, aged persons, etc.;
(*d*) specialized measures against certain diseases, e.g. active immunization against diphtheria and whooping cough, routine X-ray examination of chests in some occupations and age groups, risks in respect of industrial diseases, prophylactoria of various kinds, etc.;

(e) isolation or quarantine measures for infected persons, carriers and contacts;

(f) the provisions of recreation facilities and other deliberate provision for physical fitness and positive health.

79. *Specialized activities for safeguarding maternity:*

(a) Training the mother in ante-natal and post-natal needs;

(b) infant feeding and infant welfare centres in conjunction with 1 (c).

(c) the care of parturient women in hospitals, and in their own homes;

(d) district nursing in certain circumstances;

(e) see 5 (a), (e) and (d).

80. *Corrective activities*, including:

(a) Hospitals for the treatment of infectious diseases;

(b) hospitals for general surgical and medical cases;

(c) hospitals for special remedial measures, e.g. fracture clinics, venereal disease clinics, tuberculosis clinics and sanatoria, orthopædic hospitals, special senses clinics, cancer hospitals, etc.;

(d) hospitals for chronic and convalescent cases;

(e) hospitals for mental sickness;

(f) the provision of adequate nursing and ancillary personnel for the medical care of all sick persons.

81. *Adaptative activities*, sociological as well as medical, having as their objective the rehabilitation of persons recovered from immediate illness, or, the conservation of remaining physical or mental capacities in persons handicapped by permanent injuries:

(a) Institutions for the blind, the deaf and dumb, or persons otherwise crippled.

(b) institutions for occupational therapy applied to the needs of epileptics, mental defectives, etc.

82. *Economic accessory activities*, including:

(a) "Follow up" assistance for convalescents, or for recently confined mothers returning with infants to their homes;

(b) allowances to assist to maintain family or home security during the treatment of a breadwinner in hospital, e.g. for tuberculosis;

(c) the provision of creches and kindergarten facilities for the day care of the children of working mothers;

(d) actual domestic assistance during late pregnancy, childbirth, and for an adequate period thereafter;

(e) other allowances and pensions.

83. *Educative activities*:

(a) Research;

(b) medical, nursing and ancillary training to prescribed standards;

(c) educative health propaganda.

(All three are shared with university bodies and other voluntary or quasi-governmental agencies.)

84. The Royal Commission of 1871 in England "diagnosed with unfailing accuracy", as Sir George Newman points out, the defects which at that date hindered adequate sanitary protection of the population. They were set down by that Royal Commission as follows:

(a) The variety and confusion of authorities concerned in the public health;

(b) the want of sufficient motive power in the central authority;

(c) the non-coincidence of areas of various kinds in local sanitary government;

(d) the number and complexity of enactments;

(e) the needless separation of subjects;

(f) the leaving of some general Acts to voluntary adoption, and the permissive character of other Acts; and

(g) the incompleteness of the law.

85. The whole of these defects are present in Australian public health administration today, and must be corrected if the efficiency in public welfare is to be achieved. It is recommended, therefore, that

(1) there should be a definition by agreement of the responsibilities respectively of the Commonwealth, the State, and local governments;

(2) that in order to obviate the non-coincidence of health and hospital areas the whole populated portion of the Commonwealth should with the consent of the States be subdivided into "Health Districts", each sufficiently large, well populated, and affluent, to cope with all the administrative problems of health efficiently;

(3) that, in particular, the treatment of infectious diseases should be restricted to appropriately staffed and suitably built hospitals, bearing in mind the fact that at the present time there is an unnecessary multiplicity of small infectious diseases wards attached to country hospitals; that they are seldom used, and almost never efficiently equipped or conducted in accordance with the dictates of preventive medical practice, in so far as isolation of patients and staff is concerned;

(4) that training in the principles of public health be considerably higher than is now the custom, be obligatory inclusion [*sic*] in all universities having medical schools subsidized by the State, and the rudiments of health education be included in the school courses in all States.

86. Apart from the immediate considerations affecting sanitation and the control of infectious diseases, there is an urgent need for appropriate government action to control as a national problem mental disease, tuberculosis and venereal disease among a variety of other social problems discussed elsewhere.

Tuberculosis.

87. The present position regarding tuberculosis in Australia is a reproach to all who, possessing knowledge of the facts, have not done everything in their power to secure substantially improved facilities and increased financial provision to provide for early detection of the disease, economic security for the tuberculous and their dependants, and modern facilities for treatment and, in suitable cases, occupational rehabilitation. Had these adequate services been provided, tuberculosis in Australia would now be a rare rather than a relatively common disease.

88. It is estimated by public health authorities that there are in Australia today approximately 30,000 cases of tuberculosis, most of whom are in need of, and would greatly benefit by, modern treatment. But as notification of this disease, though legally compulsory, is very ineffectively carried out, it is impossible to estimate the total incidence of the disease in its various forms. Most important, although the numbers cannot be assessed, are those who are unknowingly suffering from the disease in an incipient form and who would also benefit from early treatment and a period of industrial convalescence.

89. In its recommendations to the Government (see Appendix "A", dated 13th January, 1943) the Committee dealt with the economic aspects of the tuberculous. We drew attention to the unanimous opinion of medical authorities that the economic factor was of primary importance and was considered the most important factor in the campaign against tuberculosis, and recommended payment of special rate pensions to the tuberculous and dependants' allowances approximating a weekly amount of £4 3s. for a man, wife and children.

90. The matter has on several occasions been considered by the National Health and Medical Research Council, whose recommendations have not been given effect. It was dealt with exhaustively by Dr. M. J. Holmes in a noteworthy report (Appendix "D") to the Federal Health Council dated the 1st March, 1929, which, had it been acted upon, would have resulted in a marked improvement in the position. Regrettable as the delay has been, it is not too late to remedy the situation, though in the interim valuable lives have been lost and needless suffering has been caused.

91. How then is this insidious disease to be effectively combated?

92. Expert medical opinion considers that the essential activities of a tuberculosis service can be broadly grouped under three main headings:

(1) Search for persons who have a tuberculosis infection sufficiently developed to warrant the use of the word "disease", either active or inactive.

(2) Treatment of the disease in a sanatorium; and

(3) After-care and rehabilitation of patients discharged from the sanatorium.

92. Because of the economic factors already referred to, the patient—where he is the breadwinner—is reluctant to stop work and leave his family unprovided for, until with the development of the disease, his physical condition compels him to do so. He is then in a much more serious condition and the prospects of a cure are proportionately lessened. Meanwhile his family and associates have been exposed to active infection.

93. In evidence before the Committee, Dr. Bruce White, who has considerable specialist experience in tuberculosis, stated:

"I regard the tuberculosis problem as being essentially an economic one. The disease, in my opinion, definitely thrives in conditions of poverty. Those patients whose economic status is good on the whole do far better than the poor. I attribute this largely to freedom from want, and, to a certain extent, freedom from worry—although even amongst the wealthy a certain amount of worry about the complaint must always exist.

"The remedy must be full provision for food with the very best, including unlimited supplies of milk, eggs, butter and other goods, not only for the individual affected, but for his immediate contacts. In addition, there must be full provision for housing and clothing of the contacts, particularly where the breadwinner is the victim. The present pension rate together with child endowment and other allowances is ridiculously low."

This view is supported generally by medical witnesses.

94. For the reasons set out in the Committee's letter of the 13th January, 1943, we most strongly urge the earliest possible adoption of the recommendations therein made for the payment of special rate pensions to the tuberculous and allowances to dependants. It is realized that this will involve a considerable expenditure, but it should be remembered that this is inescapable if we are to grapple with this disease which, while it remains unchecked, will continue to account for a great deal of economic wastage in manpower apart from the distress and loss of life occasioned thereby.

95. Having established economic conditions conducive to a successful anti-tuberculosis campaign, much systematic remedial action remains to be initiated.

Detection of the Disease in Early Stages.

96. Proposals for the locating of sufferers from tuberculosis in its early stage, when a complete cure is most likely to result from prompt and expert treatment, which are endorsed by high medical authorities include:

(1) Skin testing by the "Mantoux" method of young children at school age, and continued at five-yearly intervals;

(2) mass miniature X-ray examinations of the population on a systematic and uniform scale, and particularly of adolescents at the age of 15 years and into adult life;

(3) provision of chest clinics and chest hospitals, where patients could be examined and can be accommodated for observation, diagnosis and treatment, and where X-ray and other diagnostic aids would be readily available;

(4) improvement in, and modernization of, methods of diagnosing and treating tuberculosis as taught to students at teaching hospitals attached to medical schools.

97. Skin testing is a very simple process and only involves the application of harmless fluids. If properly organized, it could be undertaken by school medical officers when children first attend school, or by attendance at a clinic equipped with suitable facilities for this service. If done in the home, the co-operation of the medical profession would be necessary. In any case, the public would need to be educated to the advantages of skin testing so as to secure the co-operation of parents, and the organization of a programme on a systematic basis for testing all children.

98. The public would need also to be educated to the value of submitting to mass miniature X-ray examinations, which can be carried out at very small individual cost. A valuable 35 millimetre X-ray survey has been initiated by the Anti-Tuberculosis Association of New South Wales, and carried on for the past three years. It recently carried out the examination by this process of the employees of a large industrial concern, with very successful results. Such an examination of the public has, for some time, been conducted by the City Medical Officer of Health in Adelaide, with distinctly beneficial results. Efforts are being made to institute similar examinations by other local health authorities in several States, but difficulty is being experienced in securing the necessary equipment, of which there is a scarcity owing to wartime priorities. Much preparatory work can now be done, however, and at the termination of hostilities a considerable amount of valuable and suitable equipment will be released for civil use by the defence medical services, who have successfully used miniature X-ray photography for the examination of all enlisted personnel. In view of the particular susceptibility to tuberculosis of adolescents, special facilities should be provided for such examinations to be made of all in this age group, and continued, periodically, until the early years of adult life. While miniature X-ray examination is not claimed to be conclusive in its results, it is acknowledged as the most valuable *preliminary* examination that can be made for a large number of people at a reasonable cost, and the most important single procedure in the diagnosis of tuberculosis.

99. There is unanimous agreement among competent medical authorities as to the essential need for the establishment of well equipped chest clinics at general hospitals in all the larger centres of population, where suitable facilities and equipment should exist for observation and diagnosis, and where suspected tuberculosis sufferers should be accommodated under congenial conditions. Severe criticism has been made of the locality and conditions surrounding at least one such clinic in a large city. It is recognized that valuable work is being done at the few existing clinics in Australia. In his report already referred to, Dr. M. J. Holmes makes a strong case for the provision of chest clinics, and this also is strongly advocated by the National Health and Medical Research Council (see Report dated 3rd February, 1937) and by all tuberculosis specialists who have submitted evidence on the subject. It has been estimated that a suitable and well equipped clinic with accommodation for twelve beds would cost in the region of £20,000—one clinic per 150,000 people has been suggested. A specially trained staff would need to be provided, but this could be arranged in consultation with the hospital authority concerned, or, if found necessary, by special courses of training to be instituted. It is considered that the tuberculosis physician in charge of such a clinic should be a salaried medical officer devoting his full time to the work.

100. In furtherance of its active campaign against tuberculosis, the Anti-Tuberculosis Association of New South Wales has established a diagnostic and therapeutic clinic in the Sydney metropolitan area, complete with radiological and laboratory facilities, and with a professional staff and technicians in attendance. Honorary medical officers attend at set hours. Modern out-patient treatment is provided but in-patient treatment is unavailable owing to the absence of bed accommodation. In twelve months there were 19,426 attendances (not all tuberculous) and 4,780 X-ray photographs were taken. A government subsidy for the Association of £2,125 *per annum* is paid for the work at this clinic. We desire to highly commend the work of the Association in this field and for its activities generally.

101. It is alleged that because of the limited facilities at chest clinics at teaching hospitals, the methods and standards of treatment of tuberculosis are (with some exceptions) not in conformity with modern methods in other countries; also that the instruction given to medical students is often antiquated, and that there is considerable room for improvement in, and modernization of, methods of diagnosing and treating tuberculosis as taught to medical students.

102. As laymen, we are unable to confirm or refute this statement but, if upon expert inquiry it is sustained, it is a matter of serious importance calling for immediate correction.

Treatment in Sanatoria.

103. The Report of the Medical Survey Sub-Committee (see Appendix "D") discloses a serious shortage of suitable sanatoria and preventoria accommodation, and facilities for occupational therapy and rehabilitation of tuberculous patients. Also, a serious position is disclosed concerning the apparently advanced stage of the disease at which patients now enter sanatoria. This is evidenced by the report of the Director of Tuberculosis, N.S.W., in 1939, that on investigation of the after-histories of 767 patients admitted in 1934 to various sanatoria in N.S.W., it was found that during the five years up to 1939, 350 had died of tuberculosis and 329 had been readmitted to sanatoria. It is estimated that an additional 2,439 beds in sanatoria throughout Australia are needed immediately to meet active cases now in need of treatment. This disclosure, which is confirmed by medical evidence in all States, is most disturbing, and the Parliament and public generally will be concerned to learn that it is not an uncommon experience for active and, in many instances, advanced cases of tuberculosis to be refused admission to sanatoria, because of the shortage of accommodation. Frequently such patients have to wait three months for a bed,

and instances have occurred where patients have died from the disease while awaiting admission. In the interim, of course, they are highly infectious and therefore can hardly avoid spreading the disease among their associates and families and the community generally. The position has unfortunately been further aggravated by shortages of domestic nursing staffs resulting in the closing of wards in sanatoria, and also by the fact that hospitals and sanatoria for civil needs are unfavourably placed in the order of war-time priorities. The latter, as it concerns hospital provision and personnel, should be corrected with the least possible delay.

104. There have been for many years waiting lists at all sanatoria, and often the list includes as many as 200. The measures already recommended for early detection of the disease will, as a natural sequence, increase demands for accommodation as fresh cases are discovered, and this emphasizes—if such be necessary—and makes even more serious, the existing bed shortage.

105. Unfortunately, the deficiency does not only apply to bed accommodation, but medical opinion indicates that there is a serious shortage of up-to-date facilities and equipment, to provide treatment on lines recognized in other countries as essential in certain cases, including an absence of adequate surgical apparatus and operating theatre facilities. Tuberculosis specialists have stressed the need for separate accommodation for the patients in various stages of the disease, as being essential to proper segregation, control and treatment. This is an important aspect for which the earliest possible provision should be made.

106. It was urged by many medical witnesses that notifications of tuberculosis should be made more effective and that doctors should be compelled to report all active cases. Patients should also be compelled to undergo such treatment as is directed by an authorized medical officer. In view of the highly infectious nature of the disease in such cases, and the irreparable harm that may result to the patients and to their associates, by neglect or absence of proper treatment, the Committee agrees with these proposals and recommends accordingly. It is again stressed however, that the payment of the special rate pensions and allowances is an imperative preliminary to such action.

Occupational Therapy and Rehabilitation.

107. The experience overseas—particularly in such institutions as the Papworth Settlement, England, and the Altro Workshops in New York for the rehabilitation of Jewish cases, demonstrates conclusively the value of, and great need for providing, adequate facilities for the systematic development of occupational therapy and economic rehabilitation of patients whose condition has improved sufficiently to justify discharge from a sanatorium.

108. The Employment Committee of the Tuberculosis Council of Great Britain thoroughly investigated this field, and in an excellent report covering the whole field of rehabilitation of the tuberculous published in 1942, stressed the following points:

(1) Employment of patients in sanatoria.

(2) Use of training colonies where gardening, poultry farming and pig raising are taught.

(3) Introduction of Village settlements where certain industries are carried on, and where the patient and his family can be cared for as a unit.

The report included the following:

"The definition of rehabilitation of the tuberculous to be that part of the treatment of a patient which prepares him for employment consistent with his physical condition and personal aptitudes.

"Rehabilitation schemes of all kinds should be reserved for the medically necessitous, of whom the sputum-positive group should be given priority.

"Care and rehabilitation of the tuberculous is desirable, not merely as a means of restoring the working capacity of the individual, but for the purpose of raising the standards of living by providing an income adequate for the demands of his family as a whole.

"There is no longer any debate on the need for medical and social supervision of open cases of tuberculosis over a prolonged period. This is an insurance against failure of whatever procedure is adopted in the individual case."

109. It is claimed that at the Papworth Settlement in England no child born at the Settlement has contracted tuberculosis. The spread of infection has been prevented through the care and attention given to the patients and through education.

110. At Papworth a considerable quantity and variety of manufactured goods are produced, and these are disposed of on the open market.

111. The patients commence to work for two hours a day, and this is gradually increased to six hours per day. They are paid at the award rate according to the number of hours worked. The managers of the different departments are all ex-patients. The scheme is considered by medical authorities to be suitable for adoption in Australia.

112. We have been impressed with the necessity for much greater activity in the campaign against tuberculosis, a disease still responsible for some 2,500 annual deaths and, according to public health authorities, approximately 30,000 cases at the present time in Australia.

113. The Committee recommends as essential principles of the campaign:

(1) An increase in special rate pensions to the tuberculous and allowances to dependants (approximating the basic wage).

(2) Extended and improved facilities at chest clinics for early diagnosis of cases detected by the preliminary survey methods of "Mantoux" testing and miniature X-ray photography; consideration should be given to making compulsory the examination of certain age groups.

(3) Adequate follow-up of contacts and examination by these facilities.

(4) Improved accommodation and facilities for treatment, especially of early cases, in hospitals and sanatoria, by the most modern methods and technique.

(5) Greater development of after-care and of rehabilitation, including occupational therapy and village settlement of "arrested" cases.

Mental Hygiene.

114. Evidence has been adduced that much more might be done for the prevention and treatment of nervous and mental illness and for the specialized education and social utilization of the mentally deficient. The preventive aspect is being applied more and more in the work of the Departments of Mental Hygiene in all States. Especially is this so, as it should be, in the case of the mentally handicapped child. Good work has been instituted and the Departments have freely collaborated with Education and Child Welfare Departments and other agencies in this field. Child guidance clinics, opportunity classes and special schools have done much in cases of functional mental disease and mental deficiency in children; treating and alleviating the condition when it is curable, training the incurable to the limit of capacity.

114*a*. There is still much room for research and application of modern method in this field. Beyond the achievement which is possible in the individual case, any advance will help to solve those problems of modern life in which mental deficiency, character maladjustment and neurosis enter so largely—for example, child delinquency and crime; prostitution and venereal disease; and a quota of the unemployable. The Committee is of opinion that:

(1) There should be a survey by competent experts into all aspects of the problems of mental deficiency and of mental illness throughout the Commonwealth.

(2) Such a survey should concentrate especially on existing activities and future possibilities of action for the care and treatment of the mentally handicapped child.

(3) In any future developments, it is very desirable that collaboration in the field of mental hygiene should embrace all medical and health services since psychological and mental aspects enter into every field of health.

(4) There should be uniformity of legislation in respect of control of mental sickness throughout Australia.

Venereal Disease.

115. Special venereal disease legislation has been in force in every State (excepting South Australia) since 1918-19. The relevant Acts and regulations provide for an anonymous system of notification of cases. Notified sufferers who make default in submitting to treatment are followed-up and prosecuted if they do not resume treatment. Treatment by persons other than medical practitioners is prohibited. In no State is notification completely observed, but by comparing notifications with

attendances at clinics the figures do give an indication of the incidence of infection in the community. Since 1920 the trend of incidence was downwards. Less marked with gonorrhœa than with syphilis, in which disease primary cases became almost a rarity. Following the Sesqui-centenary Celebrations in 1938 there was a definite increase in syphilis and also in gonorrhœa. With the onset of war in 1939 there was, only in Queensland, any increase in total notifications. In 1941 an increase of syphilis occurred in Victoria. In 1942 there was, in those States involved in certain troop movements, a rising incidence, most marked in New South Wales, Queensland and Western Australia, and to a lesser extent in Victoria. This importation from overseas resulted in a definite increase in syphilis and also in gonorrhœa and occasioned what was new in Australian experience—the infection of girls in their early 'teens; in 1943 there has been an indication of a decrease in infection. Over the last two years the figures have shown a preponderant increase amongst females. The males in the age groups most subject to infection have been in the Services. Amongst servicemen and servicewomen there has been reported a very satisfactorily low rate of infection. The problem of venereal diseases as revealed by this wartime experience is the undoubted value of personal prophylaxis under service conditions. The other is the difficulty of control of the promiscuous girl in the 'teens and early adult life. In order to bridge the gap in State legislation, the Commonwealth Government in 1942 introduced National Security Regulations which empowered Chief Health Officers of the States to take uniform steps for the compulsory medical examination of persons suspected of venereal disease and infection with detention for treatment upon proof of infection. In practice these powers came to be utilized for the control of promiscuous girls and women suspected in those States where the situation presented most pressing problems—in Queensland and Western Australia. This matter has been the subject of protest by some women's organizations, but those responsible for the venereal disease measures have stressed the necessity for this control whilst insisting on administration remaining in the hands of responsible medical authorities and not become a general police power.

115*a*. The Committee is concerned with this problem of venereal disease as a matter which concerns the social life of the Australian community. We have taken evidence on many aspects of the problem and recommend the following measures, which should form part of a wide campaign against venereal diseases throughout Australia:

(1) A continued improvement and extension of clinic facilities.
(2) Provision of more bed accommodation for "in" patients treatment of cases of venereal disease.
(3) Provision of prophylactic facilities for civilians as well as servicemen.
(4) Continued education of the public provided that such education remains in the hands of responsible medical and health authorities.
(5) Provision for all forms of sports and for recreational and social contacts during hours of leisure.
(6) The social rehabilitation and treatment of the promiscuous girl.

Registration of Medical Practitioners.

116. The registration of medical practitioners is a State function under State Medical Acts. In each State, a medical board examines the medical qualifications of applicants for registration and controls the professional conduct of registered medical practitioners.

116*a*. There is a general uniformity between the legislation in the several States but there are some important inconsistencies. Registration and the control which is thereby exercised over the profession extend only to a State. For these and other reasons a Commonwealth-wide system of medical registration has been urged for many years. We are of the opinion that there would be many advantages in a uniform system of registration throughout Australia and that ultimately a Commonwealth system of registration should be established; and we recommend accordingly.

Food, Drugs and Poisons.

117. Commonwealth powers in respect of foods and drugs and poisons relate only to control of import and export under commerce legislation; the international obligations covering narcotic drugs (under the Geneva Opium Convention) are administered by the Department of Trade and Customs. Inspection and sale of food and drugs are dealt with in each State under Health and Pure Food Acts or special statute. Problems arise especially in the control of such an article as milk, which is both a product and a food and so subject to control by agricultural, veterinary and health services. Poisons are controlled in four States by Pharmacy Boards and in two by Health Departments. Some uniformity has been achieved in standards of food and drugs through Commonwealth and State Conferences and in recent years by the regular sessions of the National Health and Medical Research Council. A proposal was revived during 1941, for a further conference representative of governmental, professional and trade interests, to formulate greater uniformity in State legislation and administration. The National Health and Medical Research Council considered that in normal times it should be possible to achieve material progress towards a greater uniformity. The Committee concurs with this decision and urges it should be put into effect.

Medical Services.

118. The Committee believes that the issues of primary importance arising from its inquiry and the foregoing proposals are:

(1) Whether a general medical service available for all is in the best interests of the community;
(2) Whether such a service can be provided under existing conditions of private medical practice; and
(3) If not, under which of the following alternative systems of payment to medical practitioners should such a service, if any, be introduced: (*a*) a capitation fee under the panel system; (*b*) a fee-for-service under a system of private practice; (*c*) a salary for full-time employment; (*d*) a salary for part-time employment, with the right of private practice; or (*e*) a combination of any of these systems.

General Medical Service.

119. Medical witnesses generally have been more directly interested in the nature of and conditions under which medical services would be provided, than in the policy of providing a general medical service to all in the community.

120. The need for, and desirability of, such a service is questioned by some, who consider it would not be in the best interests of the community as a whole, and that if the services were rendered entirely gratuitously to such patients it would be unfairly used by many. Against this, however, is the general acknowledgement that the best medical attention should be available to all in the community, irrespective of financial circumstances. The best medical service, including specialist service, is now available to the rich, who can pay for it, and to the poor, to whom it is provided free. Upon the large middle-income group, prolonged illness or major surgery frequently imposes very considerable hardship, and, in consequence, a lowering of living standards, and results in a failure to seek advice in early stages of illness when treatment is relatively easy. In our opinion, such conditions are unjustified and inequitable. Moreover, it is unreasonable that the doctor, be he general practitioner or specialist, should be expected to give his services free to any section of the people.

121. We consider, therefore, that a general medical service should be instituted, as the best and most equitable means of providing medical care for the community as a whole; and that this should be financed from a central fund specifically raised for the purpose by a tax on income, having regard to the capacity of the individual to pay.

Capitation and Panel System.

122. There has been considerable opposition to the system of payment for medical service by a capitation fee under the panel system, which is generally associated with National Health Insurance. This system is also one of those in operation under the New Zealand *Social Security Act* (*Health Benefits*) 1938. The official attitude of the Federal Council of the British Medical Association as advised in May, 1943, is opposed to this system. It would appear that this opposition is influenced by conditions and experience of it under National Health Insurance in Great Britain, where, it is alleged, it has resulted in a lowering of the standard of medical practice owing to practitioners having enrolled on their panel lists numbers of patients out of all proportion to the number that they could effectively attend medically; and in New Zealand, where it is claimed the capita-

tion fee and conditions were unreasonable and unacceptable to practitioners. The system is also subject to abuse by patients making unnecessary calls for medical attention. On the other hand, the capitation fee system with strict limitation of the panel list, was strongly urged in evidence by Dr. R. J. Verco, President, South Australian Branch of the British Medical Association, and by Dr. T. A. Price, a Past President, Queensland Branch of the British Medical Association. Both these witnesses gave this as their personal and not their official opinion.

Fee-for-Service System.

123. The weight of medical evidence is strongly in favour of a system of fee-for-service payments to medical practitioners in any general medical service except in remote areas. This, no doubt, is genuinely influenced by a desire to retain private medical practice in its present form and to relieve the medical profession of the responsibility of continuing to provide a free general practitioner service to the poor, and free specialist services as "honoraries" at public hospitals. In Queensland, the latter system has been replaced by a part-time salaried specialist service which has proved satisfactory and acceptable to all parties. The medical profession would have much to gain by the introduction of a fee-for-service system of payment, but the system is open to grave abuse by both patient and doctor, and against this no adequate means of protection has been suggested. Neither has there been any suggestion as to any compensating reduction in fees or other concession, in return for the increased incomes practitioners would receive under fee-for-service payments for all attendances. Fee-for-service is one of the alternative methods of payment under the New Zealand *Social Security Act* (*Health Benefits*) 1938.

124. There is general support from the medical profession for the organization of medical practice in groups where complete modern equipment could be provided at a more reasonable cost to patients.

125. There has been considerable evidence in favour of a full-time salaried medical service as affording the only satisfactory basis for a National Health Service, and, at the same time, providing more acceptable and more reasonable conditions of practice for the practitioner and of security for him and his family, under a system providing a salary, superannuation and adequate provision for regular post-graduate studies. It is claimed that such a system would tend to direct the chief interest of the medical practitioner towards preventive rather than curative medicine. Support for a salaried medical service appears to be growing, and this is perhaps influenced to some degree by the deterrent effect upon the earning of very high incomes of the present very high rates of taxation. Notwithstanding this statement, the support of a salaried medical service by many leading practitioners and specialists is undoubtedly inspired by the highest motives and a sense of public duty. The weight of medical opinion appears to be against a full-time salaried service but, as mentioned earlier in this report, it has not been possible to obtain the views of the large numbers of medical practitioners in the defence forces, and it is possible that these, if known, might affect the attitude of the profession as at present indicated.

126. While, therefore, there is pronounced opposition to the scheme outlined by the National Health and Medical Research Council which visualizes a system of governmental control of all health services, there is considerably less opposition to such a service if control is vested largely in the medical profession, through an independent body with statutory authority and removed from political control. Indeed, upon this aspect of administration there is almost complete unanimity. Such freedom from political control is essential for the success of any scheme. Undoubtedly, a large section of opinion regards a full-time salaried medical service as a revolutionary proposal which might seriously affect the medical profession and its services, and, in fact, the existing social order. For this also they oppose it.

Part-time Salaried Service.

127. It has been suggested generally in evidence that any change in Health Services should be by evolutionary development, and we agree with this principle. A proposal has been made that for all cities and large country towns, a part-time salaried medical service be introduced, under which medical practitioners would voluntarily devote a portion of their time on a salaried basis, to provide a general medical service. This service would be provided at decentralized health clinics which in reality, would become out-patient consulting centres. At such centres—placed in the areas of population density in suburbs and in country towns—all modern equipment and diagnostic aids (X-ray, pathological, biochemical, etc.) would be provided. Such a service would be correlated with other clinics, public hospitals and the local health authority through a full-time medical Liaison Officer. Practitioners would retain their private practices and would be free to nominate the number of half-day sessions—if any—they would be prepared to devote to the work of the clinic. The following are suggested as the chief advantages of such a system:

(1) It is an *evolutionary* development and not a *revolutionary* change;
(2) It retains the right of private practice, either whole-time or part-time, as desired by the practitioner;
(3) It provides free choice of doctor at the clinic, within certain limits;
(4) It leaves patients the option of a "general medical" service at the clinic, or "private" attention at the doctor's surgery;
(5) It reduces the cost per patient of the most modern equipment and diagnostic aids, which few general practitioners are able to provide privately and should provide for the services of experienced consultants;
(6) It vests local control in a committee consisting of the clinic medical personnel;
(7) It relieves practitioners of routine clerical work which would be done by lay staff, and of the collection of fees;
(8) It provides a valuable potential field of re-employment for medical officers in the forces, particularly young graduates without experience of private practice (the latter now number about 1,000, and this increases annually) and young consultants.

The following disadvantages are suggested:

(1) That the part-time practitioner will naturally be more interested in his private practice than in his public duty. The practice has, in many cases, cost him a large sum and will be cherished by him as an asset of ever-increasing value. In his interest the part-time duty will invariably come second.
(2) Part-time patients may be made by the part-time practitioner to feel that they should pay for medical attention, and that, unless they do so, they are receiving charity. Medical practitioners may combine to discourage all but the very poor from taking advantage of the part-time service.
(3) As a result of the foregoing, the system of part-time service may not be in any way an adequate alternative to a whole-time salaried medical service.
(4) The failure of a part-time service would discredit any other proposal for organized and directed medical service and would thus make it more difficult to adopt a whole-time salaried medical service.

Group Practice.

128. The progress in medical knowledge and the development of diagnostic and therapeutic technique have been so great that it is not possible for the average medical practitioner to become thoroughly expert in more than a limited section of medical science, and, because of the heavy expense involved in securing modern equipment, general practitioners, except in the most favoured circumstances, find it impossible to provide such equipment in their private surgeries or consulting rooms, particularly as they would be infrequently used and, in consequence, overhead costs per patient treated would be unreasonably high.

129. It follows that the general practitioner in private practice must always be at a disadvantage when compared with a group service or hospital with modern equipment at its disposal, and where the overhead cost can be spread over a large number of patients. Moreover, the patient attending a group centre or clinic would have the choice or benefit of the doctor most experienced to deal with his particular ailment and, usually, the service of a specialist would be available on the premises, and at a much less cost than if consulted privately.

130. Medical service provided at a group centre has the great advantage to the practitioner that he would attend at specified hours and the service would be removed from his own home, where he now remains on call for a twenty-four hours-a-day service.

131. The British Medical Association has expressed its approval of group practice subject to certain conditions, of which the chief is free choice of professional associates. The Committee is impressed by the fact that, in spite of the evident advantages in group practice set out above, there has, nevertheless, been an exceptionally small establishment of group clinics by voluntary association among local practitioners. Unless some further inducement or more deliberate organization of such group clinics is provided, it believes that the successful establishment of any large measure of voluntary group practice, however desirable, is unlikely to be realized.

132. It has been suggested that such inducement might be provided by the government undertaking to establish and equip such group practice clinics as part of an evolutionary programme for establishing a national health service. One handicap to voluntary group practice is the heavy initial costs involved.

133. It will be realized that if the health centres or clinics previously discussed be accepted as an expression of group practice on a part-time salaried basis, they might provide a method of meeting by sessional payments some of the present loss on non-paying patients, who are said to represent from 15 to 20% of total consultations in general practice.

134. A part-time salaried service in a group clinic is one means by which medical practitioners could assist in providing a general medical service in return for each payment.

135. However, the proposed arrangement for the working of each clinic on a roster arrived at by mutual consent of the practitioners of each group, would permit the men engaged some respite from the twenty-four hours-a-day accessibility to the public, that is at present their position.

136. It is recognized that medical men, as others, must seek their living where their services are most appreciated and best rewarded.

137. Group practice, if founded on a basis of goodwill and willing co-operation, and with an acceptance of the view that the health of the public is a national asset, might go far to ensure that the best of medical care is available to every individual by a physician of his own choice.

138. The nation cannot afford to allow the poor—because they are poor—to become or remain sick. It must see that they receive the best medical care, including specialist care, and that the practitioners who supply such service are adequately remunerated.

Proposed Medical Service.

139. The Committee has heard a great deal of evidence on, and has given very careful consideration to a medical service for Australia, probably the most important aspect of Health Services that we are called upon to determine. We feel that the existing deficiencies in the nature and availability of medical services can only be remedied by a substantial reorganization of, and improvement in, such services. We have carefully deliberated upon the "Capitation Fee and Panel", and the "Fee-for-Service" systems for the payment of general medical services, but are unable to agree that either would, if adopted, be anything more than an expedient, and we feel that neither is likely to provide a permanent and satisfactory solution. Moreover, both these systems are open to abuses against which no adequate protection has been suggested.

140. We believe, in view of the comprehensive nature of the services required and the difficulties in otherwise providing such services satisfactorily; the need for placing the health of the people above all other consideration; the need for elevation of the medical practice to the highest plane of public duty, and the need to provide the greatest possible incentive for medical scientific research and also facilities for post-graduate study, that the ultimate solution will probably be found in a full-time salaried medical service with standardized uniform hospital provision, within which complete medical, hospital and public health services will be available to all and will be financed by a tax on incomes for this purpose. Within such a service promotion should be purely on merit. Such solution, however, must be regarded on the long range objective, since, apart from the insuperable obstacles to its introduction at this stage or until after the war, it is opposed, at present, by a large majority of the medical profession whose co-operation is vital to the success of any plan. So drastic a change would be considered revolutionary and, therefore, should not be introduced, except by evolutionary developments over a period of years. Moreover, the gradual development, in controlled stages, of a long range plan, would enable its real merits to be thoroughly tested by practical experience.

141. Having regard to all the circumstances and to the need for early and substantial reorganization of, and improvement in health services generally as indicated herein, we consider that subject to further discussions as indicated in paragraph 163 of this report, such services should now be planned, for introduction as and when the war situation permits, as follows:

(1) *For Remote Areas* (i.e., areas which now have difficulty in maintaining one general practitioner or where difficulty is experienced in securing adequate medical services)—*a Voluntary Full-time Salaried Medical Service*, under a limited-term appointment; with improved hospital and transport services, including extended ambulance and flying doctor services, and facilities for consultant services; such services to be established and extended as necessary.

(2) *For all other Areas* (i.e., cities and country towns)—*a Part-time Salaried Medical Service*, under a system of voluntary participation by general practitioners who would retain their private practices, and would nominate the number of half-day sessions they would be willing to devote to a general medical service on a part-time salaried basis. Such service should be provided at out-patients and *consulting clinics* located in the centres of population in suburban areas and country towns. Clinics would be equipped with all modern diagnostic aids and treatment facilities, and would be supervised by a salaried Medical Liaison Officer responsible to the Central Health Administration. General control of the clinics would be vested in the medical personnel of each clinic.

Hospital and Ancillary Services.

Hospitals.

141*a*. It has already been pointed out that according to the inspection of the Medical Survey Committee there were very few hospitals indeed in Australia which measured up to the standard laid down as ideal by world experience. The defects were partly in respect of construction and planning; partly in respect of accommodation and arrangement for patients; partly for staff; and partly in respect of location with regard either to centres of population or to the existence of other hospital facilities. Plans for hospitals are frequently drawn in Works Departments of the State services without other than passing reference to medical men skilled in the detail of medical needs and administrative facilities in respect of handling of patients. There is, moreover, no authoritative body to whom reference can be made either for standard plans or for the solution of a specialized problem. It would appear that this situation could only be met by:

(1) The establishment of an expert body competent to advise on hospital planning, construction and equipment for the Commonwealth.

(2) The provision by this body of uniform standards for hospitals of various types and bed capacity to meet existing deficiencies.

(3) The making good from a central fund of existing defects in hospital accommodation and equipment passing from more urgent to less urgent problems.

(4) A process of regionalization of hospitals in co-operation with State hospital authorities, (*a*) to reduce the number of inefficient hospitals; (*b*) to direct patients to community hospitals properly equipped to provide accommodation for treatment for public, intermediate and private patients; (*c*) to draw into recognized base hospitals adequately staffed with specialists, those patients requiring highly specialized treatment.

142. The difficulty of transport that existed a generation or two ago owing to bad roads and the utilization mainly of horse-drawn vehicles has passed away. A planned and organized hospital scheme as above, is incomplete, unless it provides adequate means of transport which leads to the recommendation that there should be:

(5) Improvement in facilities for sick transport by organizing ambulances and relating them to hospitals; and in the more remote districts extending the provision for Flying Doctor Services.

143. The greatest problem with which hospitals have at present to deal is the continually increasing outpatient department

which in some instances (where records are kept) has been found to have trebled during the last ten years. The greater part of outpatient work is what formerly constituted a large part of general practice and the private practitioner feels that this considerable section of his former field has been removed from him. He finds also that more and more there is growing a gap between the private practitioner and the larger hospital services where this problem is at its maximum. This fact has the further disadvantage of reducing his professional skill by limiting his opportunities for further developing it.

144. The outpatient also endures curable hardships. He must leave his work, forfeit pay for the time of absence, and sit often for hours in the outpatients' department, anxiously awaiting his turn. Even worse is the case of the female outpatient—often a mother. Prompt attention must be given the outpatients. It is therefore recommended that there should be:

(6) Decentralization of outpatient clinics; an invitation to all practising medical men where the outpatient problem is large to co-operate in its solution on a sessional payment basis. This suggestion is enlarged elsewhere in this report.

145. The proposal that there should be a standardization of hospitals with the consent and co-operation of the States leads naturally to the suggestion that there should be a classification of hospitals. It might be considered desirable that an evolutionary programme of hospital standardization in various categories might be laid down over a ten-year period; that from its inception no new hospital should be permitted to be built unless it corresponded with the standard for the appropriate category; and that, within the ten-year period, all existing hospitals should under penalty of deregistration be brought up to an adequate standard of constructional and technical efficiency.

Nursing Services.

146. The Report of the Medical Survey Committee has revealed many deficiencies in these services. There is unnecessary variation in the States in rates of pay and conditions of employment of nurses. Provision for accommodation is on the average poor. It is estimated that at least 25% of nurses in Australia are sleeping on verandahs or sharing rooms. There is little attention paid to facilities for recreation. There is a falling off in the number and type of nurses offering for training and there is a serious gap to be filled between school leaving age and the age at which a nurse enters training.

(1) The establishment of a standard course in nursing training *approved at a conference* of representative medical men and nurses for institutions throughout the Commonwealth.
(2) The establishment of standard conditions of employment, i.e. pay, leave, accommodation, etc., for the Commonwealth.
(3) Filling the gap between school leaving age and the age at which a girl enters on nursing training by an extension of the system of preliminary training schools or the establishment of a college of nursing.
(4) Measures to be taken to attract suitable girls to enter the nursing profession.
(5) The setting up of a new classification of workers in hospitals, i.e. assistants in nursing, to relieve nurses of much of the domestic work they are now required to perform.
(6) Nursing lectures to be taken in duty time and not in the nurse's off-duty time.

Ancillary Services.

147. Ancillary services, laboratory, X-ray, etc., are markedly deficient in many hospitals. This is particularly noticeable in country centres. These services are vital to the efficient practice of medicine:

(1) Where constructional and equipment facilities already exist it should be staffed by trained personnel.
(2) Those districts which lack these facilities should be provided with them at the earliest opportunity.
(3) Arrangements for the training of both medical and lay staff in these aspects of hospital care should be extended to provide (*a*) an adequate supply for initial staffing; (*b*) a steady and regulated flow of trained personnel for replacement purposes.

Administration.

148. Important among the basic principles of any Health Scheme to be determined, is the form of administration, and this involves a clear conception of the nature of the service to be provided. Assuming that health services are to be Commonwealth-wide in scope, and are to be financed from a Commonwealth fund raised by taxation for the purpose, it will need to be determined whether

(*a*) with the consent of the States, the scheme will be administered by the Commonwealth, as a Commonwealth service, under a system of decentralized authority, or
(*b*) the Commonwealth will lay down the broad principles of a health service and general hospital standards, and subject to acceptance of these principles and standards, will finance the States under a system of grants-in-aid, in order that uniformity of health services and hospital standards may be established generally throughout the whole of the Commonwealth.

149. Under a Commonwealth controlled and financed comprehensive health service, i.e., embracing public health, preventive medicine including research, general medical services and hospital services, a central Commonwealth authority such as a Commonwealth Health Commission would be necessary, to lay down and direct a policy to establish approved standards for public and private hospitals, to control medical personnel and services and, generally, to co-ordinate the activities of the various subsidiary State authorities. The personnel of such a Commission might consist of:

(*a*) A Chairman selected from a small panel nominated by the Medical Profession.
(*b*) A Medical-hospital administrator selected from a small panel nominated by the medical profession; and
(*c*) The Commonwealth Director-General of Health and Chairman, National Health and Medical Research Council, appointed for a term of five years.

150. An alternative to the above personnel might be a Commission of five consisting of

(*a*) a Chairman and two medical members selected from a panel nominated by the medical profession, one of whom shall be a medical hospital administrator and one a general practitioner;
(*b*) the Commonwealth Director-General of Health and Chairman, National Health and Medical Research Council; and
(*c*) one lay representative, with special qualifications and wide experience of finance.

As compared with a Commission of three medical men, the latter proposal has the advantage that the lay member could also be regarded as the representative of the public, appointed by the Government.

151. While, as this report has already noted, the Commonwealth Parliament's express power over health is limited, that power may be widened by the people's vote or by the States' agreement. And without any such express extension, the Commonwealth Parliament may grant to such States as are willing to co-operate the money required for the decentralized administration of Health Scheme. It would, of course, be legally possible for a State to refuse to co-operate but in practice it would be impossible for any State to refuse to become the instrument by which the great benefits of the Scheme would be showered upon its own electors. But no matter how the Scheme becomes law, it can be given life and force only by the complete and sincere agreement of all the Governments and Parliaments of Australia.

Specific Problems.

Research.

152. Research work in Australia is at present undertaken by Commonwealth and State laboratories, some few large hospals, and still fewer specially endowed private or subsized institutions.

153. Recently the Commonwealth Government set up a fund for research and delegated to the National Health and Medical Research Council the right of recommending approval of any grant for a specific piece of research. In effect, no present grant is made without such recommendation. Nevertheless there appears to be a lack of co-ordination in the work now being carried out.

154. The power is advisory only and the period of annual grant for the purpose is liable to terminate at any time.

155. The provision might well be of a permanent annual sum and the powers of the National Health and Medical Research Council might be made complete and not merely advisory.

Treatment of Cancer and Research.

156. The treatment of cancer and research into this disease is not properly organized in Australia. There are many defects in the present system which must be made good if we wish to make any further progress in our attack on this disease which is exacting such a toll.

157. The present position calls, in our opinion, for urgent attention to the following proposals for betterment:

(1) That all the resources of surgery, X-ray, and radium treatment, physical laboratory services and other methods of combating the disease be aggregated together in one centre in each State (a central institute) which should be associated with the research facilities available.
(2) That the experience of the most competent specialist staffs obtainable be concentrated and applied to the early diagnosis and treatment of cancer in its earliest stages.
(3) Convalescent accommodation for the continuance of treatment under the supervision of the staff of the Central Institute.
(4) More accommodation for patients in the late stages of the disease.
(5) Hostel accommodation for patients undergoing out-patient treatment.

158. The erection and equipping of such a central cancer hospital is necessary in order to centralize and to ensure as far as possible the most economical use of the very costly apparatus required for research and some forms of treatment. In addition to these major needs which should at the earliest possible moment be planned under expert supervision, there are other aspects of the problem which should receive attention:

(1) An education campaign to induce the public to present themselves at once to their medical attendant where there is any reason to suspect the presence of cancer.
(2) The granting of subsidies for the purpose of research on approved subjects connected with the origin and treatment of cancer.
(3) The creation of a cancer registry for the statistical study of cancer of all kinds.
(4) The formation of a liaison between private practitioners in city and country and the appropriate hospitals, which will ensure as speedy admission as possible of recommended patients.
(5) The encouragement of practitioners in the use of central laboratories and of highly expert pathologists for the histological study of suspected tissues.
(6) The extension of the follow-up services at the main hospitals to enable them better to keep in touch with patients under and after treatment.
(7) A resumption of the Australasian Conference on cancer problems (the last Conference was held in New Zealand in 1939).

Proprietary Medicines.

159. An exceedingly great sum is spent in Australia annually on proprietary or patent medicines. Some of these medicines are ordinary prescriptions of value, bottled under a trade name; some others are valueless; others again are undesirable. There are three matters which have engaged the attention of the Committee:

(*a*) A doubt as to whether the high cost of proprietary medicines is justified in relation to their actual value for health;
(*b*) the fact that these are secret remedies; and
(*c*) the misleading and sometimes false claims often made for some of these medicines.

160. It is considered that a comprehensive enquiry should be made into these aspects of the subject with the deliberate intention of remedial action if these discrepancies are confirmed.

NEED FOR CONTINUED PLANNING.

161. Pressure of time has not allowed us to cover all the subjects which properly enter into the full range of the task allotted to us. We have, for instance, not had the time to deal adequately with:

National Fitness.
School Medical Services.
Health education for children and adults.
Planning of community Health Centres in new Building Schemes.
Baby Welfare Clinics.
Nutrition and Diet, including milk supply, especially for children.
Dental services.
Optometrical services.
Pharmaceutical services.
Almoner services.
Health aspects of the population problem.
Child and Maternal Welfare, including ante-natal care and Home Aid.
Specialists, qualifications of, and availability, particularly to country residents.
Medical Transport and Flying Doctor Services.

162. During the course of the investigation we have collected a large amount of valuable evidence which will repay study by future Committees dealing with the Health Services. In particular, we wish to draw attention to the comprehensive report drawn up by the Social Security Medical Survey Sub-Committee. This report gives a complete factual survey of the medical and hospital facilities existing today in Australia, and will form a valuable basis for further recommendations regarding the reform and improvement of the Health Services in the Commonwealth.

163. Because of the present unforeseen parliamentary situation the Committee has felt obliged to record, in this report, the progress results of its enquiry at this stage. For the same reason, our deliberations and proposals are unavoidably inconclusive and need to be continued by further consideration and development. Moreover, in accordance with our conviction that a complete outline of Health Services for Australia should be discussed by the Committee with interested parties, including the Medical Profession—which is vitally concerned in any such scheme—and the National Health and Medical Research Council, we have already advised these bodies to this effect and had actually fixed the date for a conference. We consider it imperative that this conference be continued by this Committee, or its successor, as soon as circumstances permit and, subsequently, that more complete details, of a comprehensive Health Scheme, be determined for submission to Parliament, in accordance with our terms of reference.

164. Though it is extraneous to the subject matter of this report, there is one subject to which we particularly desire to refer. This is the question of the future of education in the Commonwealth. We have taken some evidence on this matter but more evidence will be necessary before it is possible to make any recommendations. All that we are able to do for the present is to emphasize the importance of this matter as affecting the future of Australia, to state that, in our opinion, the present standard and type of education in all the States is very unsatisfactory, and to record our conviction that the time has come for education to be regarded of national rather than of State concern. We express the hope that this matter will receive serious consideration by the future Parliament.

165. For the reasons given above, therefore, our task is still incomplete, and we recommend that the investigations that have been earned [*sic*] and the point shown in the present report, be continued at some future date and brought to conclusion.

APPRECIATION.

166. Our thanks are also due to the President and officials of the British Medical Association in Australia who have been, throughout, most helpful in their suggestions and advice.

167. Firstly, we wish to express our great appreciation of the valuable assistance given to the Committee by its Secretary, Mr. Roy Rowe. Throughout the investigations of the Committee, which covered not only the present enquiry but also many other aspects of the problem of Social Security, Mr. Rowe has been untiring in his devotion to his work. The administrative arrangements made by him for the conduct of the Committee's business have never failed, and his help in the compilation of the Committee's Reports has been throughout of a very high standard.

168. In conclusion, we desire to express our sincere thanks to the many persons and organizations who have assisted us in our enquiry. Owing to the great number who have been good enough to come forward, it is not possible to express our thanks to each individual case. We wish, however, to record our deep appreciation of the work done by the Chairman, Members and Staff of the Medical Survey Sub-Committee. During the short time at its disposal, just over three months, the Sub-Committee has carried out comprehensive investigations on medical and

hospital conditions in all the States of the Commonwealth. It has spared neither its time nor its energy in gathering the facts of the situation and it has, working under great pressure, compiled a report which will remain of great value for years to come. But for the work of this Sub-Committee, the task of the Committee would have been rendered much more difficult.

(Signed) H. C. BARNARD, Chairman.
W. J. COOPER, Deputy Chairman.
J. J. ARNOLD, Member.
M. BLACKBURN, Member.
J. A. PERKINS, Member.
R. S. RYAN, Member.

Canberra,
1st July, 1943.

Appendix "A".

13th January, 1943.

My dear Treasurer,

re Health Services.

In response to the request of the Government, conveyed in your letter dated 17th October, 1942 (copy attached), the Joint Committee on Social Security has during the past month taken a considerable volume of evidence in several States. The evidence which has been representative of the medical profession and public interests dealt with all aspects of health services. Because of the limited time available, the inquiry has necessarily been of a general character with the view to determining the broad principles of a comprehensive scheme for Australia and the relation of such a scheme to any measures to be recommended for introduction during the war.

Although some sections of the medical profession are strongly opposed to any change in existing conditions there is general acknowledgement of the need for improved health services, including medical, hospital, and child and maternal welfare services, on a Commonwealth-wide basis. But in view of the decision of the recent Constitution Convention at Canberra to grant only conditional approval for Commonwealth powers over health (subject to co-operation with the States), consultation with the States before Commonwealth legislation is drafted, appears desirable. Moreover, some delay in finalizing the details of new health services for Australia would seem to be inevitable in view of the very considerable financial interests the States now have in hospitals and other established State health services, and in order to avoid misunderstandings which otherwise might ultimately prejudice the success of any new scheme.

National Health Insurance.

On the evidence submitted there is unanimous objection to National Health Insurance as contained in the Commonwealth *National Health and Pensions Insurance Act*, 1938. Special attention has been directed to the restriction of benefits to a particular income group, to the very limited health and social benefits and to the absence of any provisions covering the dependants of an insured person, hospital treatment and unemployment.

As the Government will be aware, the Commonwealth *Widows' Pensions Act*, 1941, supersedes the National Health Insurance provision in this respect.

There is general hostility to the scheme among the medical profession in Australia. No basis of agreement between the profession and the Government has at any time been reached, and there is general opposition to the panel and *per capita* system for medical benefits which has been discredited in Great Britain, and more recently in New Zealand, where a fee-for-service system has been introduced. There is also opposition to the principle of Approved Societies which, in Great Britain, have been reported against by Sir William Beveridge and the P.E.P. group of economists.

Generally, it is our opinion that the National Health and Pensions Insurance Bill falls far short of any plan of social security, including social services and health services, adequate for the people of Australia, and this Committee does not favour the principle of national insurance for such a purpose. In view of the overwhelming weight of evidence we strongly advise that no action be taken to implement any of the provisions of this legislation in its present form.

Health Services for Australia.

It is our considered opinion that for the reasons which follow it is not possible successfully to introduce a comprehensive health scheme in Australia during the war, but that the planning of such a scheme should be proceeded with. Accordingly, the Committee intends shortly to proceed with its inquiry with the view at no distant date to set out in principle and broad outline the basis of a scheme which it proposes to discuss in conference with representatives of the National Health and Medical Research Council and the medical profession in Australia, preliminary to the preparation of a report to Parliament.

It is our strong conviction that any action at present to implement any major scheme of medical, hospital or other related health services would seriously jeopardise the success of any comprehensive scheme for adoption at a later stage during the war or immediately following the war. It is beyond doubt that any such action at present would be considered precipitate by the medical profession and would be vigorously opposed. Good relations have been established between the Committee and the profession and we feel it is very desirable that these should be preserved. We see no difficulty in cultivating the co-operation of the medical profession so long as adequate time is allowed for working out the necessary details and for consultation, not only with the representatives of the British Medical Association but with individual members of the profession.

The Committee has given careful thought to the practicability and manner of consulting members of the medical profession individually, including some two thousand serving in the defence forces, and feels that this will present no insuperable difficulty. We consider such individual consultation regarding any major departure from existing health services, prior to the launching of any such scheme, to be absolutely imperative. It will be appreciated that if the goodwill and co-operation of the medical profession is to be secured—and we do not mean that this can be secured only by sacrificing important matters of principle—it will be obvious that no action should be taken which may be construed as being likely to prejudice the future of the medical men at present absent on service in the Forces.

Concerning any proposals for the introduction of comprehensive health services during the war, attention is invited to the enclosed copy of correspondence between the President of the Federal Council of the British Medical Association in Australia, Sir Henry Newland, and the Minister for Health, the Hon. E. J. Holloway, M.P., in which an undertaking is given by the Minister that the medical profession will be consulted and that the scheme will not be introduced until after the war. This undertaking is reaffirmed in the Minister's letter of 24th November, 1942 (copy attached).

Wartime Measures.

In order to advise on what we understand to be the Government's immediate purpose, we classify wartime measures in two groups:

(1) Services to be planned—some of which may be partially introduced—during the war, and

(2) Measures for early introduction.

Services to be Planned during the War.

The planning of a comprehensive health scheme embracing medical, hospital, child and maternal welfare services, health clinics, nutrition and ancillary services and, incidental thereto, an expert medical survey of existing health services and medical personnel throughout Australia.

The Committee is proceeding with this planning and will report to Parliament as early as possible. Meanwhile, we are giving further consideration to the proposals for:

(*a*) Improved nutrition, in order to encourage the use of proper food values;

(*b*) Measures to provide for the uniform registration throughout Australia of Medical Practitioners, Dentists, Nurses, Pharmacists and Veterinary Surgeons; and uniform laws—or a Commonwealth law—covering food and drugs;

(*c*) Maternal Welfare (supplementary to the economic aid suggested below), having regard to the need for, but difficulty in providing during the war, the additional accommodation and services that are necessary; and

(*d*) Medical and Hospital Services in remote areas, especially those at present unable to support a medical practitioner.

These services should all form part of a complete health scheme, nevertheless we hope later to suggest means by which they may be introduced at least partially, during the war. It is important, however, that no action be taken to introduce any portion until the plan itself has been adopted in principle and so that we may avoid a "piecemeal" policy unrelated to a long-range plan.

Measures for Early Introduction.

1. *Social Measures to Provide Economic Assistance to (a) Persons suffering from incapacity or temporary unfitness for work.* While it cannot be classified as a health service, sickness benefit is closely related thereto. Persons suffering from temporary illness or from incapacity which is less than 85% or is not permanent, are not eligible for the invalid pension. In most countries where comprehensive Social Security has been adopted, sickness, or some equivalent benefit, is included for temporary incapacity and for dependants' allowances.

A benefit comparable to the Invalid Pension rate, with allowances for dependants and providing for a waiting period of seven days, should be provided. A necessary provision would be to require the person concerned to undergo any reasonable treatment prescribed.

(b) *Expectant and Nursing Mothers,* for ante-natal and post-natal care covering a period of twelve weeks to enable the mother to make adequate provision for the needs of herself and her child during the period she would otherwise be least able to do so.

It is well established that the proper care and feeding of a mother in the ante-natal and immediate post-natal period has a great influence on the health of both mother and child and therefore on the health of the nation. Child and maternal welfare is a primary responsibility and assistance in this direction is well merited and recommended.

In his recent report, Sir William Beveridge said:

"The low reproduction rate of the British community today makes it imperative to give first place in social expenditure to the care of childhood and the safeguarding of maternity."

The amount of maternity benefit he recommended, viz. 36/- per week for thirteen weeks, appears to us to be not less than would be needed by a mother to make adequate provision for several weeks prior to and following the birth of a child.

The matter of medical and hospital care during maternity will be dealt with in our report. This is at present covered only partly by the Maternity Allowance being limited to certain income groups.

(c) *Tuberculosis Sufferers and Their Dependants.* Acknowledged medical experts claim that with proper preventive measures and adequate curative facilities tuberculosis could be almost, if not entirely, eliminated from Australia. The present facilities and powers, however, fall tragically short of requirements and in consequence the disease goes on largely uncontrolled, gathers in new victims—chiefly children and young people, many of whom, under proper segregation and care, would be saved from this fate. In most, if not all States, accommodation for treating diagnosed cases is hopelessly inadequate and largely because of this, little or no progress has been made for advanced types of institutions to provide for the vocational rehabilitation of those who have progressed sufficiently to be discharged from sanatoria, or for segregation of the children of tubercular cases.

It has been stressed frequently by the National Health and Medical Research Council and it is supported by independent medical witnesses before the Committee that "the economic factor is definitely the most important aspect of the campaign against tuberculosis". Medical opinion confirms the fact also that in numerous cases the breadwinner—when threatened with early tuberculosis and being unable to provide for his family should he cease employment to undergo treatment or to voluntarily enter a sanatorium—continues his employment until he becomes badly affected. In such cases, because of the advanced stage of the disease, cure is both difficult and rare and in the meantime the members of his family and his workmates have been exposed to infection. Moreover, the psychological reactions on the patient are disastrous.

It is a melancholy fact that, due to the stress of war conditions, the urgently needed facilities—both preventive and curative—for dealing effectively with tuberculosis, are unobtainable. But we desire to most strongly recommend to the Government the payments of special pensions and allowances to tuberculosis sufferers and their dependants in order that improved economic circumstances may help to prevent the further spread of the disease among families and so that sufferers in the early stages may be given every possible opportunity of a cure and subsequent rehabilitation.

In its report the Committee will deal in detail with other measures it considers necessary to combat tuberculosis. Our desire here is to urge the payment of the undermentioned pensions and allowances.

In 1937 the National Health and Medical Research Council recommended, in cases of tuberculosis, payment of a pension similar to that paid by the Repatriation Department and the Commonwealth Invalid Pension *combined* in respect of tuberculous soldiers receiving a service pension. This would now be equal to £3 6s. 6d. per week for a man, wife and four children and for a war service pensioner *free medical treatment* in a repatriation institution. Child endowment would increase the weekly amount paid to £4 1s. 6d.

We recommend:

(1) Acceptance of diagnosed cases of tuberculosis as eligible for an Invalid Pension in the meaning of the *Invalid and Old Age Pensions Act.*
(2) Continuance of Invalid Pension to the pensioner at the *full rate* upon entrance to a hospital or institution for treatment.
(3) Payment to tuberculosis pensioners of an additional special rate pension to bring the income up to the maximum provided for any Invalid Pensioner (38/- per week), until his earning capacity is restored.
(4) Payment to his wife of an allowance of £1 per week, and to each dependant child under 16 years of a tuberculosis pensioner, 2/6 per week—exclusive of child endowment. (2/6 per week is paid for the children of a tuberculosis war service pensioner.)

These payments would make the family income for a man, wife and four children £4 3s. per week during treatment for tuberculosis. Proper treatment involves prolonged segregation and incapacity for work. Such payments would materially assist in providing the food and other necessaries in the building up and maintenance of good health, so essential to immunity from the disease.

The foregoing recommendations have for their object the provision of economic conditions essential in cases of tuberculosis. They should be implemented as the Government finds it practicable to do so and as adequate facilities are available. We recommend also the provision, as soon as circumstances permit, of the urgently needed hospital and other facilities for the prevention and cure of tuberculosis, including the segregation of children and the rehabilitation of sufferers. It is probable that a sum of £1,000,000 spread over several years will be required for this purpose.

Venereal Disease.

The attention of the Committee has been directed to the serious position regarding venereal disease in Australia, which has shown a substantial increase during the period of the war.

The method of control of the disease is well established under the State Health Departments and under recent National Security Regulations additional powers have been conferred in respect of the examination of suspected sufferers and detection of infected persons. While in some centres treatment clinics appear to be adequate, in most cases there is a pressing need for a greater number of clinics for early treatment. The serious nature and consequences of the disease are well known, but under concealment and inadequate treatment these assume grave and often tragic proportions.

Three serious aspects indicating the need for an active educational policy are:

(1) Secrecy and neglect through fear of exposure and compulsory treatment.
(2) The youth of many female sufferers.
(3) Treatment surreptitiously by unqualified persons.

Cases of infection of girls of 13 and 14 years, complicated by pregnancy, have occasionally been reported, while infection among young women from 18 to 23 years is stated to represent the main mass.

We recommend that the Commonwealth provide a sum of £50,000 for the purpose of providing clinics in the States and for educational purposes; the fund to be under the control of the Minister for Health, and that the matter of its use be determined after consultation with the States.

Child Welfare.

The extension of facilities for caring for young children, particularly those of pre-school age and during school age, and the children of mothers engaged in war industries is desirable in the interests of the nation as a whole. This could best be done in co-operation with established child welfare organizations

in the States under grants-in-aid by the Commonwealth. An amount of £100,000 should be adequate to commence with, subject to review after twelve months. If the proposal is approved we suggest the appointment of an honorary Federal Advisory Committee consisting of six women—one from each State—experienced in Child Welfare, to advise the Minister regarding the use of the grant.

The Committee will later make recommendations concerning other aspects of child welfare related to the serious population prospect confronting Australia but, meanwhile, suggests that the Commonwealth undertake more active responsibility for child welfare generally; also that a special obligation rests on the Commonwealth concerning the younger children of women who are assisting the war effort by working in war industries. The child is the best asset of the State and we neglect it to our loss.

Conclusions.

We have regarded the fixing of any base rate of benefits as being primarily a matter of Government policy and therefore have not here dealt with that aspect. We have rather related any new proposals to the accepted base rate, i.e. the Invalid and Old Age Pension rate, plus dependant's allowance as recommended in our report of the 24th September, 1941. We would point out, however, the disparity between such rates and those recommended as a "subsistence minimum" by Sir William Beveridge in his recent report to the British Government.

Yours sincerely,

(Sgd.) H. C. BARNARD,
Chairman.

The Hon. J. B. Chifley, M.P.,
Federal Treasurer,
Canberra, A.C.T.

Reviews.

A TEXT-BOOK OF MEDICINE.

DESPITE the many difficulties incidental to the war, not the least of which was the wide dispersal of the contributors, Dr. J. J. Conybeare has succeeded in publishing a sixth edition of his "Textbook of Medicine"[1] just two years after the fifth edition which was reviewed in these columns in 1941. Much valuable new matter has been incorporated in many sections, some of which have been entirely rewritten, and the author is to be especially congratulated upon his success in modernizing his matter without increasing its bulk, for the popularity of his book largely depends upon its supplying a comparatively brief introduction to medicine for the student and a compact reference summary for the busy practitioner.

As these were subjected to criticism in the review of the 1940 edition, we are glad to note that the sections dealing with the dosage of the sulphonamides and the use of the digitalis preparations have been revised in the present volume and are now quite adequate.

The interest of Australian practitioners, both civil and military, has been so quickened by the morbidity from tropical disease met with in troops operating in the Pacific zone that they will probably find the section devoted to this branch of medicine rather unsatisfying. On the whole we feel that the contributor, in view of the space available to him, has provided a reasonable and very readable summary of the important aspects of the more frequently encountered tropical diseases. There is, however, one statement in this section with which we join issue, and that is that if it is decided to give quinine for malaria by the intramuscular route the dose should be five to ten grains of the bihydrochloride dissolved in two to four cubic centimetres of sterile water or saline solution. In our opinion, if intramuscular treatment is warranted at all five grains would be a very inadequate dose, and more important, a concentration of two and a half grains to the cubic centimetre of diluting fluid is far too strong and likely to lead to necrosis of muscle and failure of the drug to be absorbed. Any concentration greater than one grain to one cubic centimetre should be strongly discountenanced.

We have stressed this point chiefly because the treatment of malaria is a major problem in Australia today, and not with any idea of detracting from what is really a very reliable and deservedly popular text-book.

[1] "Textbook of Medicine", by various authors, edited by J. J. Conybeare, M.C., D.M. (Oxon.), F.R.C.P.; Sixth Edition; 1942. Edinburgh: E. and S. Livingstone. 8½" × 5½", pp. 1167, with illustrations. Price: 28s. net.

PHYSIOLOGY IN AVIATION.

THE pleasurable anticipations aroused by the title "Physiology in Aviation" by Chalmers Gemmill, Associate Professor of Physiology in Johns Hopkins University and Instructor in Physiology in an American school of aviation medicine, are unfortunately not fulfilled on perusal.[1] It is difficult indeed to know to whom the book is addressed, for the treatment is sketchy and most of the material is to be found in any text-book of physiology used by medical students. Medical graduates in America have had an excellent discipline of training in physiology and must surely be familiar with such subjects as the transport of oxygen and carbon dioxide, the control of respiration, the effects of altitude, aeroembolism and the mechanisms of the circulation. On the other hand, to a non-medical reader the exposition would be incomprehensible, for it demands some groundwork in anatomy and physiology. Much of the text is a presentation of the work of Haldane and Barcroft, the latter name being misspelled Bancroft. Those subjects which are not included in students' text-books and which are concerned with details such as the action of altered gravity or the use of pressure cabins or pressure suits have already been expounded in a better manner in other books. There are several serious omissions, and there is really no excuse for leaving out all reference to the physiology of free fall, as this has been dealt with so admirably by the author's countrymen.[2] And when will researchers and writers in English-speaking countries give some consideration to the Coriolis force which German physicists and physiologists have been applying to flight problems now for several years?

A chapter on instrument flight by Lieutenant F. B. Lee breaks away from physiology, but could be summed up in the single sentence that in such flight all sensations are unreliable or actually dangerously misleading except visual. The book is beautifully printed on good paper.

WATERS AND WATER SUPPLIES.

WE have received the fifth edition of Thresh's well-known work on the examination of waters and water supplies by E. Suckling.[3] The fourth edition is now ten years old, and during the period that has elapsed since its publication many advances in the subjects dealt with have been made. The new edition follows closely the general scheme of the earlier one and many of the minor changes noted have been confined to insignificant phraseological alterations that have added nothing to the clarity of the original. Apart from this, however, the chapters on pollution and water-borne diseases, the bacteriology of water, purification and treatment processes have been rewritten, enlarged and brought up to date. These matters are treated fully and much useful information is presented. Other additions noted deal with iodine and fluorine in water and also the corrosion of metals in water.

In its present form, the book contains much material of practical value to persons interested in the subject. "Thresh" is regarded as the leading English text-book on water, and the fifth edition well maintains this status and can be recommended to water workers as a reliable guide from which to seek for assistance in the many problems they encounter.

It is a matter for regret, although it does not detract from the intrinsic value of the book, that Thresh's name has been relegated to a very inconspicuous position therein. It would not be too much to expect that, having regard to Thresh's pioneering and original work in the water supply field and to the fact that he laid the foundation and thereon built the superstructure of the book for a number of years, his memory would be perpetuated by the addition of his name to the title. To mention but a few standard works which in such a course is followed, we have "Osler's Modern Medicine", "Taylor's Practice of Medicine" and "Sutton's Volumetric Analysis". Why not "Thresh's Examination of Waters and Water Supplies" by Suckling? This would involve no disparagement of the present author and would be but a seemly and appropriate tribute to the original author in conformity with a usual practice.

[1] "Physiology in Aviation", by Chalmers L. Gemmill, B.S., M.D.; First Edition; 1943. Springfield: Charles C. Thomas; London: Baillière, Tindall and Cox. 8½" × 5½", pp. 136, with 18 figures and 18 tables. Price: $2.00, post paid.

[2] See THE MEDICAL JOURNAL OF AUSTRALIA, April 10, 1943, page 323.

[3] "The Examination of Waters and Water Supplies" (Thresh, Beale and Suckling); Fifth Edition by Ernest Victor Suckling, M.B., B.S., M.R.C.S., L.R.C.P., D.P.H.; 1943. London: J. and A. Churchill, Limited. 10" × 6½", pp. 859, with 63 illustrations. Price: £3.

The Medical Journal of Australia

SATURDAY, JULY 17, 1943.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

THE PARLIAMENTARY JOINT COMMITTEE'S REPORT.

EVER since July, 1941, the Parliamentary Joint Committee on Social Security has been carrying out its investigations, taking evidence in different parts of the Commonwealth and inquiring into "ways and means of improving social and living conditions in Australia". During the last few months the committee has been taking evidence from medical practitioners in all the States on the subject of a general medical service and summaries of some of the evidence have been published in this journal. It was impossible to publish an account of all the evidence chiefly because of restrictions on the use of paper. Actually it was not necessary to do so, for a good deal of repetition became obvious when views regarding the several types of service had been given. As mentioned on a previous occasion in these columns, the committee repeatedly stated that it had no preconceived plan and that it intended to sift available evidence in a search for the most suitable scheme of medical service for Australia. The committee always gave the impression that it was really in earnest in its search and there was no reason to doubt the genuineness of its statement. Readers will remember that in November of last year the Chairman of the National Health and Medical Research Council wrote to the President of the Federal Council of the British Medical Association in Australia, stating that the Parliamentary Joint Committee on Social Security had asked the National Health and Medical Research Council to consider whether the whole or any portion of the Council's outline of a salaried medical service should be introduced during the war. In view of the discussions that subsequently took place, the report of the Parliamentary Joint Committee on Social Security was awaited with considerable interest. The unexpected happenings of the last few weeks at Canberra resulted in what appeared to be the rather hurried tabling of the report just before the House dissolved.

In view of the importance to the medical profession of the Commonwealth of the Parliamentary Joint Committee's report and the consequent urgent need for practitioners to be conversant with its details, the document has been published *in extenso* in the present issue. That members may the more readily appreciate the significance of the report, one or two considerations should be brought to their notice. In the first place it should be noted that the members of the committee do not represent any one shade of political opinion or belief—its members have been drawn from every political party. It is a common and often a stupid practice to cast doubt on the *bona fides* of politicians and to look for some ulterior motive in their actions. To do this is as a rule easier than to look for a worthy motive. We do not believe that the members of the committee agreed with tongue in cheek that (in the words of clause 138) "the nation cannot afford to allow the poor—because they are poor—to become or remain sick. It must see that they receive the best medical care, including specialist care, and that the practitioners who supply such service are adequately remunerated". To suggest such a thing would be gratuitous and unworthy. At the same time it is unfortunate from the opposite point of view that the committee should have formed the impression, expressed in clause 119, that "medical witnesses have been more directly interested in the nature of and conditions under which medical services would be provided, than in the policy of providing a general medical service to all in the community". It may be that the way in which evidence was sought and the *questionnaire* used gave an impression of false emphasis. We know full well and would ask the members of the committee to believe that the great majority of the members of the medical profession are deeply concerned in the provision of a general medical service to every person in the community. The Federal Council has resolved: "That the medical profession . . . is willing and anxious to cooperate with the Government in bringing about certain essential improvements in the existing forms of medical service to the community." Cooperation between two bodies that are trying to find a satisfactory basis for a good health service is much more likely to be effective if each has confidence in the good faith of the other than it is in the presence of any lurking suspicion. It is in an atmosphere of good faith that medical practitioners should study this report. Here it may be pointed out that the committee sagely remarks more than once that the approval and cooperation of the members of the medical profession are essential to the success of any scheme of medical service.

The committee has stated the form which it thinks that the medical service of the future should take. It makes it clear, however, that the planning of services along the lines suggested should be subject to the discussions indicated in clause 163. Here it is stated that discussions should be held between interested parties—the medical profession and the National Health and Medical Research Council. Such a conference was actually planned to take place between these two bodies and the Parliamentary Joint Committee. Now that Parliament is, as it were, in the melting pot, the committee holds that the conference should be continued by it or by its successor in the next Parliament. This means that the members of the several Branches of the British Medical Association have a little more time than they otherwise would have had in which to crystallize their ideas, and in doing so to make some suggestions as to how the existing consultant, general practitioner and hospital services with all adjuncts and the necessary additions agreed to at the last meeting of the Federal Council may be made available to those who cannot pay. The view may be advanced that since the

committee regards its deliberations and proposals as inconclusive and as requiring further consideration and development, it should not have made any recommendations regarding a type of service. Opinions will differ in regard to this, but the fact remains that recommendations have been made. The result is that when the representatives of the Federal Council meet representatives of the National Health and Medical Research Council with the Parliamentary Joint Committee on Social Security appointed by the new Parliament, they will probably be asked to express their opinions on the long-range plan envisaged in the report under discussion. If they do not agree that a voluntary full-time salaried service is suitable for remote or sparsely populated areas and that a part-time salaried medical service should be set up for other areas, they will need to have some other suggestions to put forward in their place. In the short period of time that remains the Branches may still state their views on different types of service. Having done this, they should instruct their representatives to the Federal Council which will meet at the end of August in regard to their several preferences, giving the Federal Council authority to act on their behalf. The Federal Council should then adopt the view of the majority and the others should acquiesce in the decision. In no other way will finality ever be reached.

Current Comment.

PREGNANCY AFTER THORACOPLASTY.

MOST medical practitioners, it may be assumed, would agree that a woman who had suffered from such an advanced and unresponsive form of pulmonary tuberculosis as to require thoracoplasty should not be allowed to undergo the ordeal of pregnancy. If a woman did become pregnant in such circumstances there would be two reasons for apprehension. In the first place it might be supposed that pregnancy and labour would cause the tuberculous disease to spring once more into activity, and secondly, the lung condition would not unreasonably be expected to interfere with normal progress of labour. Thoracoplasty is not an operation that is frequently employed, though it is recognized to have a place in the surgical treatment of tuberculosis. Still less often will the question of pregnancy arise in regard to a tuberculous woman who has been treated in this way. In spite of this, attention should be drawn to a series of 40 cases reported by F. R. Stansfield[1] from which he concludes that women suffering from pulmonary tuberculosis who have responded to thoracoplasty may be safely allowed to marry and have children provided their home conditions give reasonable comfort. One of the 40 cases has been observed by himself and the others have been collected from the literature. In 36 cases the interval between the performance of thoracoplasty and the occurrence of pregnancy varied from a few months to several years; the longest interval was nine years. In four cases the operation was successfully performed during pregnancy; the age of these patients is not stated, but the labour is stated to have been normal in each instance and the result good for both mother and child. In eight cases the tuberculous condition was reactivated either during the pregnancy or within two years of delivery and one mother died from amyloid disease. Stansfield states that the authors who reported these eight cases blamed faulty home conditions for the reactivation rather than the pregnancy. This must be taken to mean that reactivation would have taken place, whether pregnancy occurred or not. There is no way of judging whether home conditions were really to blame—six of the eight cases were reported by two authors who wrote together and a sceptical critic cannot help wondering whether the wish was the father to the thought. In three cases in the series dyspnœa was troublesome during pregnancy and labour. Forceps were used in six out of forty deliveries. The result of the whole series was that 38 healthy children resulted from 48 pregnancies. This report is interesting and would have been more valuable had a little more detail been given. The wise practitioner will accept Stansfield's conclusions with reserve and will realize that each case will present its own peculiar problems. No generalization is admissable.

[1] *The Journal of Obstetrics and Gynæcology of the British Empire*, December, 1942.

AVIDIN IN THE TREATMENT OF CANCER.

BIOTIN, a growth-promoting vitamin, has been known for quite a number of years; it was designated first as vitamin *H* and later as part of the B_2 complex. It was then discovered that a state of biotin deficiency could be produced in rats by feeding them with large quantities of egg-white. A compound could be isolated from egg-white which combines with the biotin and thus obviates its activity. The name "avidin" was given to it. It has also been claimed by V. P. Sydenstricker *et alii* that a state of biotin deficiency similar to that in rats could be produced in man.[1] Clinical evidence of such deficiency (desquamative macular dermatitis, ashy grey pallor, papillary atrophy of the tongue, mental changes, hyperæsthesia, paræsthesia, anorexia or nausea) developed in four to twelve weeks, when normal persons received a diet with a very low biotin content to which avidin in the form of egg-white was added. Proof that this state was actually due to biotin deficiency was seen in the fact that the urine of such persons contained abnormally small amounts of biotin. As other investigations had shown by this time that some neoplasms contained very high amounts of biotin and that certain experimental tumours apparently need biotin for their proliferation, a new point of attack of the cancer problem seemed to be given. If one could deprive neoplasms of a substance essential to their growth, a great advance in the treatment of malignant tumours would be made. The advantages are so obvious that probably many such investigations have been initiated. There are, however, hardly any published reports as yet. L. P. Rhoads and J. C. Abels[2] record an attempt at evaluating this procedure on two patients, one a woman with a carcinoma of the breast which had already extended through the chest wall and had metastasized into the liver, the other a man with chronic lymphatic leuchæmia. The fact that the therapy was of no avail in either case and did not alter in the least the expected course of their diseases can perhaps not be regarded as very significant. In both cases the disease was so advanced when treatment was commenced that nothing short of a miracle could have saved the patients. Of far greater importance are the results of the investigation of their biotin metabolism. In the case of the first patient it became evident that, in spite of the administration of avidin in amounts sixteen times greater than required to bind the biotin contained in the diet, the biotin excretion in the urine was not diminished; strangely enough, it was on occasions even higher than before. Also in the case of the second patient no decrease of the biotin excretion occurred. The reasons for these observations are still a matter for speculation. The authors further report that certain experimental tumours in mice were not influenced if a state of frank biotin deficiency was introduced.

Although no evidence for the value of avidin therapy has thus come forth, Rhoads and Abels themselves insist that the investigation of only two patients is not sufficient for them to form a definite opinion about its possibilities. The position at the present moment may be summed up by the statement that the results so far published are a warning against undue optimism, but do not contraindicate further investigation of the problem.

[1] *Science*, February 13, 1942.
[2] *The Journal of the American Medical Association*, April 17, 1943.

Abstracts from Medical Literature.

MEDICINE.

Pneumonia Deaths.

J. C. MEAKINS AND R. C. MCKENNA (*The Canadian Medical Association Journal*, February, 1943) have analysed the deaths from pneumonia among 200 patients subjected to sulphonamide therapy at the McGill University Clinic, Royal Victoria Hospital, Montreal. There were 21 fatal cases, all among persons over forty years of age, sixteen being in males and five in females. The death rate was high among Type III infections, and there was a high incidence of bacteriæmia. Malnutrition or associated disease involving the cardio-vascular system, lungs, kidneys, liver or sinuses was present in over 90% of fatal cases. In five cases one lobe, in eight cases two lobes, in four cases three lobes, and in three cases four lobes were involved. In only four of the fatal cases was sulphonamide therapy begun as early as the second day, and in two cases no specific therapy was given. Early specific treatment and anti-shock therapy were suggested, since seven patients presented clinical features of shock which was not treated.

Pneumonia.

HARRISON F. FLIPPIN, LEON SCHWARTZ AND ALBERT DOMM (*The Journal of the American Medical Association*, January 23, 1943) record their experience of the modern treatment of pneumococcal pneumonia in a series of 1,635 adult patients. The therapeutic drugs used were sulphapyridine, sulphathiazole and sulphadiazine, and the mortality rate averaged 10·6%. It was observed that the drug of choice was sulphadiazine, but the authors insist that it is not to be employed to the exclusion or neglect of other established therapeutic measures. They recommend a dosage scheme of an initial three grammes by mouth followed by one gramme every six hours till the patient is afebrile for forty-eight hours and clinical improvement is manifest. The authors make the following salient points of observation relative to the therapy of this disease: early treatment, adequate chemotherapy including a large initial dose and subsequent smaller doses at regular intervals with a continuance of the drug till convalescence is established, the maintenance of adequate urinary output, the routine use of alkalis, the prompt recognition of drug toxicity, the determination of specific pneumococcus type, and the employment of other therapeutic measures such as general supportive treatment, the use of type specific serum and surgical intervention, when necessary.

Motility of the Fasting Stomach in Health and Disease.

W. F. ANDERSON (*The Lancet*, January 9, 1943) has recorded movements of the empty stomach by measuring the changes of pressure in a balloon passed into the stomach. In healthy persons, fasting, three phases of gastric motility were demonstrated: active contractions, "tonus rhythm", and relative quiescence. No relationship between the acid-secreting power and the motility of the fasting stomach was demonstrated. In ten patients with acute duodenal ulcer gastric tone was increased and contractions were stronger than in the healthy stomach and liable to end in tetanus. Abnormality of the gastric motility was also demonstrated in other diseases. In eight patients with peptic ulceration the ingestion of cold water, which inhibited gastric contractions in health, had no inhibitory action and in some cases actually had an excitatory effect. The results of some of the experiments gave support to Hurst's view of the pathogenesis of pain in duodenal ulcer, namely, that the important factor is an increase of muscle tension due to spasm of the pyloric sphincter accompanied by deep peristaltic waves.

Coronary Arterial Disease in Diabetes.

K. SHIRLEY SMITH (*British Heart Journal*, January, 1943), who has analysed the clinical features of 49 consecutive cases of diabetes associated with heart disease, endorses the well-known principle that in patients with heart disease sudden reductions of blood sugar by diet or insulin are not well tolerated. In general, he concludes that the use of insulin will be in such dosage as to reduce severe hypoglycæmia and abolish acetonæmia: to use insulin to procure "exact control" of the diabetes in patients with additional heart disease is to court disaster. He points out that anginal pain in the diabetic is related not only to ischæmia, but to metabolic disorders in the heart muscle: angina may be produced by excessive lowering of the blood sugar by insulin.

Correspondence.

SAP DERMATITIS AND CONJUNCTIVITIS CAUSED BY THE WILD FIG (FICUS TUMILA).

SIR: The letter by Major English and Captain Grey in THE MEDICAL JOURNAL OF AUSTRALIA of June 26 on the subject of wild fig sap dermatitis is very interesting. Might I ask that the chief botanist at the various State Botanic Gardens be notified officially. I know that Mr. R. H. Anderson keeps an index of all reports on toxic plants and timbers of Australia.

With regard to the occurrence of the dermatitis on the penis, I should like to make a simple suggestion, namely, that this localization is most likely due to the handling of the penis during urination by men whose hands had become soiled with this sap.

As to the axillary localization, I suggest that this is due to transference of sap from the hands to axilla in the course of taking a shower bath.

It would be interesting to find out whether all people are susceptible or only a few individuals, and what component of the sap, like the glucosides in *Rhus toxicodendron* and *Primula obconica*, is responsible for the irritant action.

Yours, etc.,

235, Macquarie Street, Sydney, June 29, 1943. E. H. MOLESWORTH.

SIR: In the current number of your journal appears the report of a case of "Sap Dermatitis and Conjunctivitis Caused by the Wild Fig (*Ficus tumila*)" by Major P. B. English and Captain L. P. Grey.

This has been brought to my notice by Mr. W. J. Ellis, an officer of this Division's Biochemistry Section, who is interested in this subject and thinks that we may be able to demonstrate the principle in the sap responsible for its irritant action. Mr. Ellis states:

"It has been shown that several latex-bearing trees and plants have an active proteolytic enzyme in their latex, the most commonly known of these being papain, the enzyme from the papaw. Many of these enzymes have been studied by us, including some collected from a number of common weeds. The enzyme content of some of these latices is in many cases of sufficient activity to cause severe lesions when allowed to come into contact with the skin. For example, those people employed in harvesting papaws find it essential to wear gloves to protect their fingers.

"Since some members of the fig family have been shown to possess proteolytically active latex, it would appear possible then that it may be this property which is responsible for the dermatitis recorded.

"Perhaps the editor of THE MEDICAL JOURNAL OF AUSTRALIA would be good enough to pass this note on to the authors, who may be interested to send along a small sample of the latex for testing. That is, of course, if it is still available to them. For dispatch, it may be prepared as follows:

(*a*) One volume of latex added to two volumes of acetone, or

(*b*) one volume of latex added to two volumes of absolute alcohol, or

(*c*) spreading the latex in a thin layer on a piece of clean glass and drying at room temperature out of the direct sunlight; when dry, scraping up and putting into bottle. If the tree has to be lanced for collection, it is essential to use glass, ebonite or stainless steel.

"Finally, we should also like to refer to their identification of the tree. We can find no mention of a species *tumila* and have consulted both the Melbourne Herbarium and University Botany Department, who both state they have no record of such a species. It is possible that the authors mean *Ficus pumila*, which is a vine, but here again lies some doubt, since they (the authors) say two wild fig trees—if it was vine they would hardly refer to it as a tree. In view of this we would be pleased to hear of their source of identification. If there should be any doubt, they could send along a small specimen of the plant and we could have it identified here."

If any samples are to be sent, would you please have them addressed to Mr. W. J. Ellis, Biochemistry Section, Division of Industrial Chemistry, Council for Scientific and Industrial Research, Parkville, N.2, Victoria.

Hoping that this work may be of mutual benefit,

Yours, etc.,

I. W. WARK,

Chief of the Division.

Council for Scientific and Industrial Research,
Division of Industrial Chemistry,
Lorimer Street,
Fishermen's Bend,
Melbourne.
June 30, 1943.

Naval, Military and Air Force.

CASUALTIES.

ACCORDING to the casualty list received on July 7, 1943, Major B. Ingram, A.A.M.C., Hobart, is reported to be dangerously ill.

According to the casualty list received on July 7, 1943, Major E. L. Corlette, A.A.M.C., Orange, Captain M. J. McNamara, A.A.M.C., Mosman, Major A. A. Moon, A.A.M.C., Neutral Bay, and Captain J. S. S. Winter, A.A.M.C., Toorak, who were previously reported missing, are now reported to be prisoners of war.

According to the casualty list received on July 8, 1943, Captain J. E. R. Clarke, A.A.M.C., Brisbane, who was previously reported to be "missing, believed prisoner of war", is now reported to be a prisoner of war.

According to the casualty list received on July 9, 1943, Captain J. D. Morris, A.A.M.C., Oakleigh, who was previously reported "missing, believed prisoner of war", is now reported to be a prisoner of war.

Obituary.

ALFRED FRANCIS STOKES.

WE regret to announce the death of Dr. Alfred Francis Stokes, which occurred on July 1, 1943, at Adelaide, South Australia.

FRANCIS BARTLETT CRAWFORD.

WE regret to announce the death of Dr. Francis Bartlett Crawford, which occurred on July 3, 1943, at Richmond, Victoria.

Nominations and Elections.

THE undermentioned have applied for election as members of the New South Wales Branch of the British Medical Association:

Wurth, Donald James, M.B., B.S., 1943 (Univ. Sydney), Sydney Hospital, Sydney.
Dodson, Leigh Frederick, M.B., B.S., 1943 (Univ. Sydney), Saint Vincent's Hospital, Darlinghurst.
Keen, John Alexander, M.B., B.S., 1943 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.

Australian Medical Board Proceedings.

TASMANIA.

THE undermentioned has been registered as a duly qualified medical practitioner:

Jones, Allan Hackett, M.B., B.S., 1942 (Univ. Sydney), Devon Hospital, Latrobe.

Books Received.

"Social Insurance and Allied Services: Memoranda from Organizations", Appendix G to Report by Sir William Beveridge; 1942. London: His Majesty's Stationery Office; Melbourne: Robertson and Mullens Limited. 9½" × 6", pp. 248. Price: 3s. 7d. (A).

Diary for the Month.

JULY 20.—New South Wales Branch, B.M.A.: Ethics Committee.
JULY 21.—Western Australian Branch, B.M.A.: Branch.
JULY 22.—New South Wales Branch, B.M.A.: Clinical Meeting.
JULY 23.—Queensland Branch, B.M.A.: Council.
JULY 27.—New South Wales Branch, B.M.A.: Medical Politics Committee.
JULY 28.—Victorian Branch, B.M.A.: Council.
JULY 29.—New South Wales Branch, B.M.A.: Branch.
AUG. 3.—New South Wales Branch, B.M.A.: Organization and Science Committee.
AUG. 4.—Victorian Branch, B.M.A.: Branch.
AUG. 4.—Western Australian Branch, B.M.A.: Council.
AUG. 5.—South Australian Branch, B.M.A.: Council.
AUG. 6.—Queensland Branch, B.M.A.: Branch.
AUG. 10.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
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Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

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